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RELEASE/EXCHANGE OF HEALTH CARE INFORMATION

Name:_____ DOB:_____
Telephone: _____ Email_____

I hereby authorize Lauren Manasse, LICSW, CEDS-C to:

OBTAIN FROM ____ PROVIDE TO ____ _____
Institution: _____
Attention:
_____Address:
_____
Telephone/Email
_____
The purpose of the exchange of information is care collaboration and coordination. Specific information to be exchanged:____ Verbal information____ Mental health records____ Medical information____ Psychological testing____ Other _____
For the time period of: _____
Please return written information to Lauren Manasse, LICSW, CEDS-C at the above address or call (617) 894 0024 to speak directly. I have carefully read and understand the above statements and expressly and voluntarily consent to disclosure of the above information about, or medical records of my condition, to those persons or agencies above. I further release my attending primary care provider and the hospital and its employees from any liability arising from the release of this information to such persons or agencies, provided the said release of information is done substantially in accordance with applicable law. I understand that this consent is subject to revocation in writing at any time, unless action based on it has already begun. This authorization will be valid for 1 year from the signature date, or until_____

_____Client signature
Date
_____Clinician signature
Date

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LICSW 1020734