Consent for Release of Confidential Information

Client's Name: _____ DOB: _____

Legal Guardian: _____

By signing below, I agree to give PBJ Connections permission to exchange/give/receive/share/re-disclose information regarding treatment with the following named person/agency/organization:

_____

Information exchanged may include treatment plans/progress, psychiatric/psychosocial assessments, diagnosis, educational results and any other information related to the treatment of said client. Information will be utilized for mental health/behavioral health treatment of the client, including information pertinent to other treatment team members.

This document is valid for 12 months.

Pursuant to Federal Regulations, this information will not be forwarded to any other provider or agent.

_____

Client Date

_____

Parent or Legal Guardian Date

On Behalf of PBJ Connections, Inc.:

_____

Clinician Date

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Fax: 740-924-2002
Phone: 614-395-1395 (confidential) 740-924-7543 (general)