CONSENT FOR EXCHANGE OF CONFIDENTIAL INFORMATION

Child and Community Counseling LLC
9135 North Meridian Street, Suite A-6
Indianapolis, Indiana 46260
(317) 581-1433
childandcommc@gmail.com

By signing this authorization, I authorize exchanged information for the following purpose:______Clinical evaluation and/or consultation

Other Provider Name/Organization/Person:

____

Phone:______________________**Fax:**____________________________

City, State, Zip:____

\- -

Patient Name:____

Date of Birth:____

Street Address:____

City, State, Zip:____

(I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA privacy rule. I understand that I have the right to revoke authorization any time in writing.)

____________________________ Patient/Parent/Guardian Signature	____________________________ Witness Signature
____________________________ Printed Name	____________________________ Witness Printed
____________________________ Date Signed	____________________________ Date Witnessed