LeeBascom MSW, LCSW

EXCHANGE/RELEASE OF INFORMATION

I,_____
Client name or parent/guardian name if child is under 18

_____
Child's name under 18

_____
Date of birth of client

Hereby authorize Lee Bascom, MSW, LCSW and the program/person identified below to communicate and disclose to one another written and verbal information regarding my/ my child's treatment:

Name: _____

Organization: _____

Address: _____

City/State/Zip: _____

Phone: _____

The purpose for such disclosure is to improve assessment and treatment planning, share information relevant to treatment when appropriate, coordinate treatment services, or for the purpose identified below:

_____

_____

Lee Bascom LLC does not have my permission to disclose the following items:_____

_____

I understand that my records are protected under the federal regulations governing the Health Insurance Portability & Accountability Act of 1996 (HIPAA) and cannot be disclosed without written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this consent at any time, except to the extent disclosures have already been made in reliance on this or any other consent. Revocation may be accomplished per written request and may be for specific items or the entire release.

This consent will automatically expire one year from date of signature unless otherwise noted.

Signature of Client or Parent/Guardian:_____
Date_____

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