

PIN: _____



755 Martin Luther King Jr. Way, MSC 9022
Harrisonburg, VA 22801
540.568.4908 (phone)
540.568.3886 (fax)

Authorization to Exchange/Release Confidential Information

I understand that different agencies provide different services and benefits, and that each agency must have specific information in order to do so. By signing this form, I am giving permission for the following agencies to exchange/release information so that they can work effectively together to provide/coordinate services and benefits on my behalf.

Client's Full Name (PRINTED)

Client's Social Security Number

Client's Date of Birth (Month/Day/Year)

Client's Address

City

State

Zip Code

The person completing this form is:
 Self Parent Power of Attorney Guardian Other Legally Authorized Representative

I, _____ authorize JMU-Occupational Therapy Clinical Education Services

- To release the following information to
- To obtain the following information from
- To exchange the following information with

the individuals/agencies listed below on an ongoing basis, for the duration of the terms of this release.
This release applies to the following information (*check all that apply*):

Name of Individual/Agency	Credentials (MD, OT, PT, SLP, School)	Contact Info (Phone # and/or Address)
1.		
2.		
3.		
4.		

Assessment Information Treatment Session Information

For the purpose of: _____

This information is released with the understanding that I may revoke this authorization at any time except to the extent that the person or entity authorized to release this information has already acted in reliance on it. I understand that if this information concerns alcohol or substance abuse diagnosis and treatment, it is protected by Federal regulations (42 CFR Part 2) and cannot be released without this authorization.

This authorization will expire automatically on _____
(Maximum of one year from the date signed)

Client, Parent or Authorized Signature

Date

WITHDRAWAL OF CONSENT:

Client, Parent or Authorized Signature

Date