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AUTHORIZATION TO DISCLOSE/EXCHANGE INFORMATION

I, _____ (hereinafter "Client") hereby authorize The Center for Cognitive and Behavioral Health, LLC (hereinafter "Provider") to disclose / exchange mental health treatment information and records obtained in the course of treatment including, but not limited to, doctor or therapist's diagnosis to:

Name: _____

Address: _____

Telephone: _____ Fax: _____

The specific uses and limitations of the types of health information to be released are as follows (check all that apply):

- Treatment Coordination
- Treatment Planning
- Diagnostic Refinement
- Other: _____

Such disclosures shall be limited to the following types of information:

- Full Treatment Record (can include any or all of the information below)
- Psychiatric Diagnosis (es)
- Dates of Treatment
- Treatment Summary
- Treatment Plan
- Psychiatric Evaluation
- Psychotropic Medication Record
- Discharge Summary
- Psychological Testing
- School Reports
- Medical Reports
- Other: _____

This Consent to Disclose/Exchange Information expires on _____ or one year from the date of signature, whichever comes first.

Date Signature of Patient/Parent or Guardian Relationship to Child

Date Signature of CCBH Provider