Michelle Feeney, LCSW
Cheri Neadle, MS LMFT
Betsy Shah, LCSW
Nicole Eastwood, LCSW RYT
John Lieberman, LPC
Alexandra Bolan, LCSW
Lakshmi Kandel, LCSW

Laura Schacter, LCPC RYT
Maura Henninger, ND CNS
Lindsay Tiscia, LCSW
Kristy Rancourt, LCSW
Jessica Newton, LCSW
Kristine Weidner, LCSW

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):

- o Treatment Coordination
- o Treatment Planning
- o Diagnostic Refinement
- o Other: ____

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

- o Full Treatment Record (can include any or <u>all</u> of the information below)
- o Psychiatric Diagnosis (es)
- o Dates of Treatment
- o Treatment Summary
- o Treatment Plan
- o Psychiatric Evaluation
- o Psychotropic Medication Record
- o Discharge Summary
- o Psychological Testing
- o School Reports
- o Medical Reports
- o 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