Children's Psychological Services, LLC

Dr. Valerie Roth, Psy.D.
drvalerieroth@gmail.com
941-877-0284

Consent for Exchange of Information

Client Name _____Date of Birth _____

I authorize Dr. Valerie Roth to disclose _____ and/or **receive** _____ information from the following:

Name and/or Organization _____

Address_____

Telephone Number_____Fax_____

the following health care information:

☐ Health care information relating to the following treatment or condition:
_____

☐ Health care information for the date(s) below:
_____

☐ All health care information:
_____

☐ Other_____

This authorization ends: _____in 90 days _____until termination of counseling_____other

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I understand that my records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. Once the information is given out, the recipient might re-disclose it.

I acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

Signature of Parent / Legal Guardian _____

Witness / Therapist_____

Date_____