



## Release of Confidential Information • Consent Form

I, \_\_\_\_\_, hereby authorize Bailey McDonald, LISW-CP to exchange verbal and written information, as specified below, regarding my treatment, with those persons/entities specified below, in accordance with the HIPAA Act of 1996. I understand that I may revoke this consent at any time by informing the parties listed below, as well as Bailey McDonald, LISW-CP, in writing. In consideration of this consent, by signing below, I hereby release the parties listed below from any legal liability for the release of this information. Furthermore, I acknowledge that I have received, read, and understand the two-page HIPAA information document, which includes the clients' rights under HIPAA. **(initial):** \_\_\_\_\_

### Information Type Codes (for use on next page):

- |   |   |   |
|---|---|---|
| <input type="radio"/> 1 <input type="radio"/> Account/Billing | <input type="radio"/> 2 <input type="radio"/> Assessment            | <input type="radio"/> 3 <input type="radio"/> Designated Record Set |
| <input type="radio"/> 4 <input type="radio"/> Diagnosis       | <input type="radio"/> 5 <input type="radio"/> Progress in Treatment | <input type="radio"/> 6 <input type="radio"/> All of the above      |
|   | <input type="radio"/> 7 <input type="radio"/> Other (specify)       |   |



Date	Code # for Information to Disclose	Person / Entity	Signature