CONSENT FOR EXCHANGE
OF PERSONAL AND HEALTH INFORMATION

PARENT / CAREGIVER INFORMATION:

LAST NAME	FIRST NAME	MIDDLE NAME	RELATIONSHIP TO CHILD

CHILD'S INFORMATION:

LAST NAME	FIRST NAME/MIDDLE INITIAL	DATE OF BIRTH
ADDRESS	CITY, STATE, ZIP CODE	PHONE NUMBER

THE PERSON OR AGENCY BELOW MAY ***EXCHANGE*** MY CHILD'S INFORMATION:	INFORMATION EXCHANGED MAY INCLUDE:
Arkansas Families First, LLC **4004 McCain Blvd. Ste 203** **North Little Rock, Arkansas 72116** **Phone: 501-812-4268; Fax: 501-812-4286**	**__ All Information Relevant to Consultation** **OR** __ Psychological / Educational Evaluation Results __ Psychological Treatment and Diagnostic Records __ Billing and Payment Records __ Medical, Health, or Developmental Information __ Psychological, Behavioral, Educational Information

INFORMATION MAY BE EXCHANGED WITH THE FOLLOWING PERSONS OR AGENCY(IES):

Agency Name: ______________________	Agency Name: ______________________
Contact: ______________________	Contact: ______________________
Address:______________________	Address:______________________
City, State, Zip: ______________________	City, State, Zip: ______________________
Telephone: ______________________	Telephone: ______________________
Fax: ______________________	Fax: ______________________

VOLUNTARY: I know that I do not have to sign this consent form. I can refuse to sign this consent form, although disallowing collaboration between involved parties may limit the quality of services my child receives from any of the agencies.

LENGTH OF TIME: This consent will be valid from the date that I sign this form until ___________ (date). If no date is entered, the form will be valid until *the date that I terminate services* with Arkansas Families First, LLC.

WITHDRAWAL: I know that I can withdraw this consent at any time. To withdraw my consent, I must send a written note to the person or agency. The withdrawal will be valid as soon as the person or agency gets my note, but will not apply to information that has already been shared after I signed the consent form.

SHARING OF INFORMATION: I know that my child's information may be shared more than once by the persons and/or agency(ies) listed above. The information may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It may still be protected by other State and Federal laws. Arkansas Families First, LLC is not responsible for further release of information by other agencies.

COPY: A copy of this consent form will be as good as the original. I know that I have a right to get a copy of this consent form if I ask for one.

Signature:	Date:
Relationship to patient:	