CONSENT FOR RELEASE OF PERSONAL AND HEALTH INFORMATION

PATIENT'S INFORMATION:

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

ARKANSAS FAMILIES FIRST, LLC is hereby requested to release the specified records/information to the following individual or agency:

Agency Name: ____

Contact Person: ____

Address: ____

City, State, Zip: ____

Telephone: ______________________ Fax: ______________________

DESCRIPTION OF INFORMATION TO BE RELEASED:

__ All Information Relevant to Consultation, Treatment and Diagnosis

OR

__ Psychological / Educational Evaluation Results
__ Psychological Treatment and Diagnostic Records
__ Billing and Payment Records
__ Medical, Health, or Developmental Information
__ Psychological, Behavioral, Educational Information
__ Other Information (specify):

REASON FOR RELEASE OF INFORMATION: __coordination/continuity of care __other (specify): ______________________

VOLUNTARY: I know that I am not required to sign this consent form and that I will not be refused treatment if I do not sign this form. I can refuse to sign this consent form, although disallowing collaboration between involved parties may limit the quality of services I receive 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 OF CONSENT: I know that I can withdraw this consent at any time. To withdraw my consent, I must send a written notice to the person or agency asked to release this information. The withdrawal will be valid as soon as the person or agency receives my notice, but will not apply to information that has already been shared after I signed the consent form and before receipt of the withdrawal notice.

SHARING OF INFORMATION: I know that my 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 may serve as the original. I know that I have a right to obtain a copy of this consent form if I request one.

Signature:	Date: