CONSENT TO SHARE CONFIDENTIAL INFORMATION

I, _____

(Patient name)

Authorize Jonathan Farrell-Higgins, Ph.D. to:

Share or exchange information with: _____ Obtain information from: _____

Name and Address:

_____

_____

_____

Please indicate the nature of the information shared for treatment purposes:

____ Psychological Report

____ Consultation Report

____ History and Physical Exam

____ Verbal Summary of Treatment

____ Social History

____ Intake/Discharge Summary

____ All Pertinent Information

____ Other

I understand that my medical records (including any alcohol, drug, or psychiatric info) may be protected by Federal Regulations. This consent to disclose may be revoked by me in writing at any time except to the extent that action has already been taken.

I indemnify and hold **Jonathan Farrell-Higgins, Ph.D.** harmless from any and all damage or prejudice which might result to myself, relatives, or heirs from the use or misuse of information furnished by persons pursuant to this authorization.

Signature of patient:_____ Date:_____

PROHIBITION ON REDISCLOSURE: This document contains clinical information whose confidentiality is protected by law. Federal regulations (42 CFR part 2) provide that this material may not be redisclosed to anyone without the expressed written consent of the person to whom it pertains. A general authorization of release of medical or other information is NOT sufficient for this purpose.