Coordination of Treatment Consent

In accordance with Federal and State confidentiality laws, it is necessary for those involved in you or your child's treatment to be able to exchange information. Your signature on this form will allow outside groups and individuals to exchange confidential information necessary to you or your child's treatment. Please Note: No medical records will be released without a signed Release/Disclose Protected Health Information form.

Name of Patient: _____ Date of Birth: _____

I authorize the following identified member(s) of my/my child's treatment team to communicate with McClintock Therapies for the purpose of ongoing care:

_____

Individual/Agency Name

_____

Individual/Agency Name

_____

Individual/Agency Name

I understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance on it. Such revocation will be discussed and may result in an inability to treat. I understand written notification is necessary to cancel this authorization and must be addressed directly to McClintock Therapies. I understand that this consent automatically expires 90 days after the end of treatment.

Patient's Signature: _____ Date: _____

I acknowledge that the clinical and legal purpose and intent of this form has been explained to me.

Parent/Guardian Signature: _____ Date: _____