CONSENT FOR EXCHANGE OF CONFIDENTIAL INFORMATION

COMMUNITY PSYCHOLOGICAL CONSULTANTS
9102 North Meridian Street, Suite 400
Indianapolis, IN 46260
(317) 574-1785
Fax: (317) 574-1786

By signing this authorization, I authorize exchange of information for the following purpose: Clinical evaluation, consultation, and coordination of care. **Between the following provider(s) and the following organization/person:**

__Mary L. Sanders, Ph.D., HSPP
__ Daniel H. Stauber, M.A., LCSW
__Jacqueline L. Hess., Psy.D., HSPP
__Katherine Glaser, MSW, LCSW
__Rachel Feldwisch, PhD,MA,LMHC,ATR-BC
__Bryn W. Dungan., Psy.D., HSPP
__Jennifer L. Godar., Psy.D., HSPP
__Sarah Brown, Psy.D., HSPP
__Lindsay A. Hallett, Psy.D.,HSPP
___ Ronald M. Westrate, Ph.D., HSPP

Name/Organization: _____

Phone #: _____ **Fax #**_____

Street Address_____

City, State, Zip _____

Patient's Name_____

Patient's Date of Birth: _____

Street Address_____

City, State, Zip _____

I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand that I have the right to revoke this authorization at any time in writing, except to the extent that the medical provider named above or Community Psychological Consultants has acted in reliance upon the authorization. I understand that this authorization will expire in **90 days** or when **patient turns 18** years old which ever comes first.

_____
Signature of Patient/Parent/Guardian

_____
Witness Signature

_____
Print Patient/Parent/Guardian

_____
Witness Name Printed

_____
Relationship to Patient

_____
Date Witnessed

Date Signed _____