North Shore Family Services

Consent to Release/Exchange Confidential Information- Over 18

I, _____, hereby give my consent to North Shore Family Services, LLC and its agents or employees, to release or exchange information* about me with:

Primary Care Physician_____
Street Address_____
City, State, Zip_____
Phone_____ Fax _____ Email: _____

Work/School_____
Supervisor/Teacher_____
Other school professionals/Title(s) _____
Street Address_____
City, State, Zip_____
Phone_____ Fax _____ Email: _____

Other professional (circle title: OT, PT, speech, psychiatrist, psychologist, specialist, etc.)_____
Title: _____
Street Address_____
City, State, Zip_____
Phone_____ Fax _____ Email: _____

Other professional (OT, PT, speech, psychiatrist, psychologist, specialist, etc.) _____
Title: _____
Street Address_____
City, State, Zip_____
Phone_____ Fax _____ Email: _____

Other professional (OT, PT, speech, psychiatrist, psychologist, specialist, etc.) _____
Title: _____
Street Address_____
City, State, Zip_____
Phone_____ Fax _____ Email: _____

**This information may include written reports, verbal reports, and/or relevant family information. Such information will be used for collaboration and coordination of services. You have the right to inspect and copy any written records prior to disclosure.*

Copies (or facsimiles) of this release are to be treated as having the same validity as the original. However, if the consent is revoked after a disclosure has occurred, the revocation has no effect with respect to prior disclosures.

Signature of client_____ Date: _____

Parent(s)/Guardian's Signature:_____ Date: _____

This consent is valid for one year from signed date.