

# Purposeful Parenting , LLC

## Confidential Information Consent

I, \_\_\_\_\_, do hereby consent and authorize **Purposeful Parenting LLC, LLC**. as indicated below to obtain from and release to:

\_\_\_\_\_  
Name of person / Title / Organization

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Address / City / State / Zip

\_\_\_\_\_  
Phone Number

The following information pertaining to:

\_\_\_\_\_  
Client Name

\_\_\_\_\_  
Client's Date of Birth

\_\_\_\_\_  
Expiration Date

### THE INFORMATION WHICH MAY BE DISCLOSED IS:

OBTAIN    RELEASE

- |                          |                          |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Presence in treatment (admit/discharge dates) |
| <input type="checkbox"/> | <input type="checkbox"/> | Medical history and physical examination      |
| <input type="checkbox"/> | <input type="checkbox"/> | Discharge Summary/Continuing care plan        |
| <input type="checkbox"/> | <input type="checkbox"/> | Educational records/achievements/assessments  |
| <input type="checkbox"/> | <input type="checkbox"/> | Psychological tests/protective assessments    |

OBTAIN    RELEASE

- |                          |                          |                                     |
|--------------------------|--------------------------|-------------------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Bio-psychosocial/diagnostic summary |
| <input type="checkbox"/> | <input type="checkbox"/> | Health records                      |
| <input type="checkbox"/> | <input type="checkbox"/> | Educational testing records         |
| <input type="checkbox"/> | <input type="checkbox"/> | Immunization records                |
| <input type="checkbox"/> | <input type="checkbox"/> | Medical discharge summary           |

Other: \_\_\_\_\_

### THIS INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSES:

- To provide ongoing treatment / continuing care
- To provide educational services
- Coordinate services with authorized school officials
- To coordinate educational planning and re-entry program with school persons
- To enable judges, attorney, probation / parole officers to support treatment goals or make legal decisions on my behalf
- Other: \_\_\_\_\_

I UNDERSTAND THAT I NEED TO CONSENT TO RELEASE OF INFORMATION IN ORDER TO OBTAIN SERVICES. I CHOOSE TO DO SO WILLINGLY AND VOLUNTARY FOR THE PURPOSE SPECIFIED ABOVE. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME BY NOTIFYING THE ADMINTRATOR IN WRITING, EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON MY CONSENT. SIGNING OR NOT SIGNING THIS CONSENT WILL NOT AFFECT THE QUALITY OR QUANTITY OF SERVICES.

\_\_\_\_\_  
Print Client Name

\_\_\_\_\_  
Signature of Client and Date

\_\_\_\_\_  
Print Parent/Guardian Name

\_\_\_\_\_  
Signature of Parent/Guardian and Date

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
Signature of Provider and Date

**NOTICE TO RECIPIENT OF INFORMATION:** Information has been disclosed to you from records whose confidentiality is protected by Federal or Indiana laws and regulations. Such laws prohibit you from making any further disclosure of the information without specific written consent of the person to whom the information pertains or as otherwise permitted by such laws and regulations. A general authorization for release of medical or other information is not sufficient for this purpose. The Federal and Indiana laws and regulations restrict any use of the information to criminally investigate or prosecute any patient.