Wynns Family Psychology
130 Preston Executive Drive, Suite 202
Cary, NC 27513
Ph: (919) 467-7777 | Fax: (855) 797-9587

CONSENT TO RELEASE & EXCHANGE PATIENT INFORMATION

I want the following information shared for treatment planning and/or service coordination. By signing this form, I am allowing service providers or agencies to exchange information that will be useful in planning current treatment, and/or will make it easier for them to work together effectively in planning and/or providing services.

Patient Name _____ Birth Date _____

I authorize Wynns Family Psychology to exchange:

- ☐ Psychological/Diagnostic Evaluation
- ☐ Educational Assessment
- ☐ School Records
- ☐ Progress Update
- ☐ Medical History
- ☐ Developmental History

This Information should only be exchanged with:

Name(s)/Agency _____
Address _____
Phone _____ Fax _____ Email _____

Name(s)/Agency _____
Address _____
Phone _____ Fax _____ Email _____

Name(s)/Agency _____
Address _____
Phone _____ Fax _____ Email _____

Expiration & Terms: I understand that this consent is good until one year from the date of my signature below, and that it encompasses consent to release information from before the signature date as well as additional information received after this consent is signed. In addition, I understand that information may be shared in writing, via email, in computerized form, and/or in meetings or by telephone.

Revocation: I understand that I can withdraw this consent at any time. The revocation will not apply to information that has already been released. I must revoke this Consent in writing to Wynns Family Psychology. This will stop the listed parties from sharing information after they know my consent has been withdrawn. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Patient Signature _____ Date _____

If a personal representative of the patient signs the authorization, a description of such representative's authority to act for the patient must be provided.

Signature of Parent/Guardian _____ Date _____