CONFIDENTIAL EXCHANGE OF INFORMATION FORM

Patient Name:_____ **D.0.B** _____

Patient Address:

A. Treating Behavioral Health Clinician/Facility Information

Name Jeanne Trifone, PsyD - Challenges of Life Counseling LLC Phone (941)740-2140

Address 1777 Tamiami Trl - Suite 304-2
Port Charlotte, FL 33948 Fax (941)732-6032

B. Medical Clinician Behavioral Health Clinician Other Professional Personal Contact:

Name Phone

Address Fax

By initialing all information items I approve, I authorize release of the following medical information to the Health Care Practitioner named above. **Check and initial all that apply:**

□ Mental Health Diagnosis_____

□ Medication Management Information_____

□ HIV/AIDS Related Records (Except HIV Test Results) _____

□ Other Mental Health Treatment Information _____

□ Other Information specified here_____

□ Substance Abuse (SA) Information _____

For SA information, this authorization is:

Limited to the following treatment _____

Limited to the following time period_____

OR

o I do **NOT** wish to have information shared with:

o My PCP/medical practitioner □ My other behavioral health clinician(s)/provider(s)

Confidentiality of alcohol and drug abuse patient records is protected under federal law. Federal regulations (42 CFR, part 2) prohibit anyone from making any further disclosure of the information without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

I understand that the release of this information is to permit my treating physician and other health care practitioners to monitor my health status and to coordinate all the care which I may receive. This authorization, unless otherwise indicated, becomes effective on the date signed and may be revoked by me at any time, except to the extent action has been taken in reliance herein. If not earlier revoked or instructed, this authorization shall terminate automatically within one year of the date of execution. I understand that the information authorized by this release will be provided to those recipients only with signed consent from me. I further understand that I have a right to receive a copy of this authorization upon my request.

_____ _____

Signature of Patient or Legal Guardian Date