Louisa Psychological Consulting, P.C.

Office location:
102 Elm Avenue
Louisa, VA 23093

Mailing address:
P.O. Box 2189
Louisa, VA 23093

FAX: 540-500-5916
Phone: 540-223-0837
psych4kids@ntelos.net

CONSENT TO EXCHANGE INFORMATION

I, _____, am signing this form for
(Full printed name of consenting person(s)

_____
(Full printed name of client)

_____
(Client's Address) (Client's Birth Date) (Client's SSN-Optional)

My relationship to the client is: ☐ Self ☐ Parent ☐ Power of Attorney ☐ Guardian
☐ Other Legally Authorized Representative

I want the following confidential information about the client to be exchanged:

Yes	No		Yes	No		Yes	No	
☐	☐	Assessment Information	☐	☐	Medical Diagnosis	☐	☐	Educational Records
☐	☐	Financial Information	☐	☐	Mental Health Diagnosis	☐	☐	Psychiatric Records
☐	☐	Benefits/Services Needed Planned and/or Received	☐	☐	Medical Records	☐	☐	Criminal Justice Records
			☐	☐	Psychological Records	☐	☐	Employment Records

I want Louisa Psychological Consulting, PC, 102 Elm Avenue, P.O.Box 2189, Louisa, VA, 23093
Contact Aleta Strickland telephone 540-223-0837, fax 540-500-5916, e-mail psych4kids@ntelos.net

And the following other agencies or persons to be able to exchange this information:

_____

_____

I want this information to be exchanged ONLY for the following purpose(s):
☐ Service Coordination and Treatment Planning ☐ Eligibility Determination

Other: _____

Information may be exchanged by written, computerized and verbal methods.

This consent is good until _____ .

Signature(s): _____ _____
(Consenting Person or Persons) (Date)

Person Explaining Form: _____
(Name) (Title) (Phone Number)

Witness (if required): _____
(Signature) (Address) (Phone Number)