

5975 Parkway North Blvd., Suite D
Cumming, GA 30040
(p) 404-388-3909
(f) 678-712-1945

3060 Kimball Bridge Rd., Suite 110
Alpharetta, GA 30022
www.focusforwardcc.com
info@focusforwardcc.com

Consent to Release Confidential Information

I, _____, hereby authorize an exchange of confidential medical information between the following persons or agencies:

1. FFCC, Inc. _____	2. _____
5975 Parkway North Blvd., Suite D _____	_____
Cumming, GA 30040 _____	_____
Phone: (404)388-3909 _____	Phone: _____
Fax: (678) 678-712-1945 _____	Fax: _____

The following items may be copied and or provided:

- | | | |
|---|--|--|
| <input type="checkbox"/> Treatment Attendance | <input type="checkbox"/> Level of Participation | <input type="checkbox"/> Treatment Plan |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Psychiatric Reports | <input type="checkbox"/> Psychological Reports | <input type="checkbox"/> Consultation Report |
| <input type="checkbox"/> Laboratory Reports | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Medical Reports |
| <input type="checkbox"/> Educational Reports | <input type="checkbox"/> Disciplinary Reports | <input type="checkbox"/> Testing Results |
| <input type="checkbox"/> Legal Documents | <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Verbal Communications |
| <input type="checkbox"/> Other: _____ | | |

The disclosure of information is required for the following purpose(s):

- Coordination of Treatment
- Referral to/from _____ .
- Other: _____ .

I understand that this consent is revocable, in writing, at any time prior to its expiration which will occur on _____.

Client's signature Date

For minor: Parent/Legal Guardian Signature Date

Clinician's Signature Date