CONSENT FOR COMMUNICATION WITH MEDICAL PROVIDERS FOLLOWING ASSIST SCREENING AND REFERRAL

PLEASE READ THE BELOW INFORMATION CAREFULLY BEFORE SIGNING.

Consent for release of medical information

I, _____ (print name of client), give permission for my health provider _____ (print provider's name), to share the following information (outlined, below) regarding my treatment and care, with [**Insert Agency Name and Service/Program**] in order to coordinate care following ASSIST screening to ensure they are informed of my treatment and care process.

Information to be shared:

_____
_____
_____
_____

Client Signature: _____ Date: ____/____/____

Your consent is effective until _____ (insert date).