**CONSENT FOR COMMUNICATION**

**FOLLOWING INTIMATE PARTNER VIOLENCE 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 screening for intimate partner violence, to ensure they are informed of my treatment and care process.

Information to be shared:

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

**Client Signature:** __________________________________________ **Date:** ____/____/____

***#onsent is effective until __________ (insert date).***