PIN: _____

James Madison University
Occupational Therapy Clinical Education Services
Phone: 540-568-4980 Fax: 540-568-2645

Mailing Address:
755 Martin Luther King Jr. Way, MSC 9022
Harrisonburg, VA 22801

Physical Address:
131 W. Grace St., Rm 1100
Harrisonburg, VA 22807

Authorization to Exchange/Release Confidential Information

I understand that different agencies provide different services and benefits, and that each agency must have specific information in order to do so. By signing this form, I am giving permission for the following agencies to exchange/release information so that they can work effectively together to provide/coordinate services and benefits on my behalf.

_____
Client's Full Name (PRINTED)

_____ _____
Client's Social Security Number Client's Date of Birth (Month/Day/Year)

_____
Client's Address City State Zip Code

The person completing this form is:
__Self __Parent __Power of Attorney __Guardian __Other Legally Authorized Representative

I, _____ authorize JMU-Occupational Therapy Clinical Education Services

_____ To release the following information to

_____ To obtain the following information from

_____ To exchange the following information with

Name of Individual/Agency	Credentials (MD, OT, PT, SLP, School)	Contact Info (Phone # and/or Address)
1.		
2.		
3.		
4.		

the individuals/agencies listed below on an ongoing basis, for the duration of the terms of this release.
This release applies to the following information *(check all that apply):*
____Assessment Information ____Treatment Session Information

For the purpose of: _____

This information is released with the understanding that I may revoke this authorization at any time except to the extent that the person or entity authorized to release this information has already acted in reliance on it. I understand that if this information concerns alcohol or substance abuse diagnosis and treatment, it is protected by Federal regulations (42 CFR Part 2) and cannot be released without this authorization.

This authorization will expire automatically on _____
(Maximum of one year from the date signed)

_____ _____ _____
Client, Parent or Authorized Signature Date

WITHDRAWAL OF CONSENT:

_____ _____ _____
Client, Parent or Authorized Signature Date