Hoffmann Ψ Burchett Psychological Services, LLC
205 N. Williamsburg Drive, Suite F
Bloomington, IL 61704

Consent for Exchange of Information

I, _____, authorize **Hoffmann Burchett Psychological Services, LLC**
(Client or Parent/Guardian)

to exchange information regarding treatment of _____ with the following person(s):
(Client Name and Date of Birth)

Name: _____

Agency: _____

Address: _____

Telephone: _____

Fax: _____

This consent for exchange of information is for the purposes of:

_____

and shall be limited to the following specific types of information:

☐ Initial/Diagnostic Assessment ☐ Discharge Summary ☐ Social History ☐ Health History ☐ Medication

☐ Psychological/Vocational Testing ☐ Treatment Plan ☐ Treatment Progress ☐ Entire Record

☐ Information required for insurance coverage ☐ Other _____

I fully understand the nature and the intent of this authorization. I understand that my consent is completely voluntary, and may be withdrawn, in writing, at any time. This authorization expires one year from the date signed. A copy or facsimile of this consent is considered as valid as the original.

Signature of Client and/or Parent or Legal Guardian(s):

_____ _____
Client or Parent/Legal Guardian Date

_____ _____
Client or Parent/Legal Guardian Date

_____ _____
Client or Parent/Legal Guardian Date

Signature of Psychologist:

_____ _____
Licensed Psychologist Date

Please note: State law prohibits making any further disclosure of this information without informed, written consent from the person to whom this information pertains.