INFORMED CONSENT for TREATMENT: I _____ (name of client), agree and consent to participate in behavioral health care services offered and provided by John Geremia, LCSW-C. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within the scope of the provider's license, certification, and training. If the client is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Consent for Release of Confidential Information to Primary Care Physician:

IF YOU DO NOT WISH TO AUTHORIZE RELEASE OF INFORMATION TO YOUR PRIMARY CARE PHYSICIAN, PLEASE INITIAL HERE: _____ (or complete the next paragraph)

I _____ hereby authorize John Geremia, LCSW-C to disclose to my primary

care physician: _____ with office location and/or phone number:

_____ , all clinical information about me, as to permit my primary care physician to monitor the continuity of care and to inform my primary care physician of my health status. This authorization becomes effective _____ and may be revoked by me in writing at any time. Unless earlier revoked be me, this authorization automatically terminates at the time treatment terminates. **I understand that this authorization does not extend to the release of any AIDS/HIV information unless I have also placed my initials here _____**. I further understand that the information authorized by this release will be released to the authorized recipient only, for purpose noted above. I understand that I (or my legal representative) is entitled to a copy of this authorization form for my records. *It is my responsibility to inform John Geremia, LCSW-C of any change in my primary care physician's information*.

Notice to Recipient: This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR Part 2) and/or state law. In accordance with federal and state law requirements, the information received pursuant to this document is **confidential** and recipient is prohibited from making further disclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise indicated by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patients.

_____ _____

Legal Signature of Client or Legal Guardian Date

_____ _____

Name of Client (Please PRINT) Witness

Print Form Save Form