CONSENT TO SHARE PROTECTED HEALTH INFORMATION

Client Name:____

Client DOB: _________________________

Client Address:____

I give permission to release information FROM:

Carrie Braverman, LICSW		____________________________________
344 Harvard Street, #1	**TO:**	____________________________________
Brookline, MA 02445		____________________________________
(617) 651-0451		____________________________________

I give permission for exchange of information (reciprocal release) between the two entities above. Initial: _______________

I do NOT authorize the release of the following information: _______________________

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I DO authorize the specific disclosure of the following information (initial next to each):
_____ **Information related to my HIV status or testing**
_____ **Information related to substance use or abuse**

This release is for the purpose of:

- ☐ **Coordination of Care**
- ☐ **Other:** ___________________________

Unless otherwise indicated, this permission will be valid for a period of 1 year from the date signed.

Client Signature:_______________________________________ **Date:**____________________

Client Name Printed:____________________________________