KINGA KONDOR-HINE
TRAUMA THERAPIST

228 Elm Dr. Rochester NY. 14609 kkondorhine@gmail.com 585-683-1049

Consent for Release of Information

Name: _____ DOB: _____

☐ I hereby give permission to Kinga Kondor-Hine to receive information from:
☐ I hereby give permission to Kinga Kondor-Hine to release information to:

Person (s): _____
Relationship: EMERGENCY CONTACT
Agency: _____
Address: _____

_____

Phone: _____ Fax: _____ E-mail: _____

Type of Contact:

☐ Legal ☐ Mental Health ☐ Substance Use ☐ Primary Care ☐ Hospital/ Inpatient ☐ Other: _____

I hereby give permission for information to be shared in the following format:

☐ Phone ☐ Fax ☐ Writing ☐ e-mail ☐ In person ☐ T-health

I hereby give permission for the following information to be shared:

☐ Intake Assessment
☐ Treatment Plan
☐ Psych/Neurospych Evaluation
☐ Mental Health History
☐ Drug & Alcohol Eval
☐ PRI Screening PTSD Screening
☐ Medical History (including physicals, lab results and medications/allergies)
☐ PPD/TB test (1 year)
☐ OT/PT/Speech Reports
☐ Orthopedic Eval
☐ Social Work Eval
☐ Employment History/Evaluations
☐ Academic Performance
☐ Other (Please specify): _____

Information will be shared for the following purpose: _____

I understand that this authorization covers only the information indicated and that Warrior Salute will maintain the confidentiality of the information. Warrior Salute is prohibited from disclosure of any records it receives through use of this release except in limited circumstances pursuant to law. I may revoke my authorization at any time with a written request. This authorization is valid from the date signed up to three months post discharge from services.

_____

Client Signature Print Name Date

The information obtained from the use of this release may only be used for the purpose of which it was intended. Any other use of this information is in direct violation of Confidentiality and is punishable by law.