18 Carlisle Street, Suite 108
Gettysburg, PA 17325
Phone # 717-420-5395
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Consent for Release of Confidential Information

I, _____, DOB _____, consent for communication and the exchange of information between _____ (relationship:_____) and Rebecca Uppercue, LCSW, regarding:

_____ Psychological evaluation / Discharge Summary

_____ Psychiatric evaluation and medication management services

_____ Physical examination and medical treatment/results

_____ Written and verbal communication related to treatment between parties

_____ Emergency contact/information

_____Other:_____

for the purpose of

___ Coordination of treatment services

_____ Emergency contact for safety of the Patient and others

_____Other:_____

Executed on this date _____/_____/_____.

This Consent for Release of Information will expire in one year on this date _____/____/_____.

By signing below, I acknowledge my medical record is protected under State and Federal confidentiality regulations and others cannot disclose my information without my written consent unless otherwise provided for in those regulations. I acknowledge I may revoke this consent at any time to the extent that action has been taken in reliance on it (examples include court order, probation, parole) and that in any event this consent expires on the date above.

_____ _____

Rebecca Uppercue, LCSW
Licensed Clinical Social Worker

Patient or Legal Guardian of Patient