CONSENT FOR COMMUNICATION FOLLOWING INTIMATE PARTNER VIOLENCE SCREENING AND REFERRAL

PLEASE READ THE BELOW INFORMATION CAREFULLY BEFORE SIGNING.

Consent for release of medical infor	mation
	(print name of client), give permission for my
health provider	(print
provider's name), to share the follow	ing information (outlined, below) regarding my treatment
and care, with	[Insert Agency Name and Service/Program] in
order to coordinate care following sc	reening for intimate partner violence, to ensure they are
informed of my treatment and care p	process.
Information to be shared:	
Client Signature:	
#onsent is effective until	_ (insert date).

[Agency Name] Revised 4/2019