ALICIA FLANAGAN, MSW LICSW

10 Concord Avenue
Cambridge, MA 02138
Phone: 617-219-9669

NAME: _____

SS#: _____

DOB: _____

Provider/Requester: I hereby authorize Alicia Flanagan, LICSW to release information to the following person in the event of a medical or mental health emergency:

Emergency Contact Name:

Address:

Phone number:

For the purpose of: *CARE DURING A MEDICAL OR MENTAL HEALTH (SUICIDAL/HOMICIDAL) EMERGENCY*

The information authorized to be released (please initial below):

____Any information related to a medical concern or emergency

____Any information needed to secure safety when suicidal or homicidal

I have been told that, in order to protect the limited confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the person listed above, and will be effective for one year after the date of my signature. A photocopy or facsimile of this form may be accepted in lieu of the original signed form. I also understand that this consent is revocable except to the extent that action has been taken on it already.

I further understand that Alicia Flanagan, LICSW will not condition my treatment on whether I give authorization for the requested disclosure.

_____

Client Signature

_____

Date

Release valid until:

_____