JANE LEGWOLD, LLC

5205 Knox Avenue South
Minneapolis, MN 55419

cell 612.250.4411
fax 612.924.3643

RECEIPT OF CLIENT INFORMATION

I have received information about *Jane Legwold, LLC's* procedural guidelines, policies and practices to protect the privacy of health information, emergency procedures, fees and Jane Legwold's competencies.

CONSENT FOR TELEPHONE COMMUNICATION

Use of the telephone presents some potential risks to privacy. However, in our desire to communicate with you in a timely manner, we will call you using the most efficient means. (Please note there is a separate consent for non-secure communication.) This may include the use of cell phones, cordless phones and/or leaving messages on voice mail. The business name *Jane Legwold LLC* will show on caller I.D. If you block calls it may result in a delay in your phone call being returned.

Please inform Jane of any specific instructions about how messages are to be returned each time you call.

I hereby give consent for the above with the following restrictions:______________________________.

CONSENT FOR CONSULTATION / RELEASE OF INFORMATION

I am aware that Jane Legwold, MS, APRN, LMFT routinely consults with other professionals and asks for her colleagues to cover for services when she is unavailable to be able to provide quality services. In that process my name and/ or identifying information might be revealed. I hereby consent to the above with the following restrictions:____________________________________ . I understand that this information will be held as confidential with the above parties, and that I have the right to revoke this consent at any time. My questions about persons involved have been answered to my satisfaction.

CONSENT FOR COORDINATION OF CARE

Jane Legwold might find it appropriate to coordinate care with your other healthcare providers. Jane will typically have you sign a formal release of information. This is to serve as general consent until such form is signed. I authorize coordination of care with ____.
(Healthcare Provider Names)

RELEASE TO CONTACT REFERRAL SOURCE

I authorize *Jane Legwold LLC/ Jane Legwold* to contact the professional, individual or agency by whom I was referred with the information that I am or will be receiving services.

Please cross out and initial any of the above to which you do not consent.

______________________	________	______________________
Signature of Client	Date	Signature of Parent / Guardian