Request/Authorization to Release Confidential Records and Information

I, _____, Date of Birth _____,

hereby authorize the following person/facility to release my medical (including specifically mental health) records/information.

Person/Facility: _____

Address: _____ Fax: _____

Records/Information will be released for the following purpose(s):

❑Patient Request ❑ Coordination of Care ❑ Treatment planning ❑ Other: _____

These records/Information released will concern the time between _____ and _____.

In the boxes below, the information to be disclosed is marked by an X.

❑ Intake Note/Progress Notes/Treatment Plan/Closing Summary ❑ Psychological evaluation(s)

❑ Verbal case/treatment information/history ❑ Other: _____

Records/Information will be released to the following person/facility.

Person/Facility: _____

Address: _____ Fax:_____

HIV-related and drug and alcohol information contained in these records will be released under this consent if not marked below:
❑ Do not release HIV-related information ❑ Do not release drug and alcohol information.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 1 year from the date on which it is signed.

_____ _____

Signature of client Date

_____ _____ _____

Signature of parent/guardian/representative Relationship Date

_____ _____

Signature of witness Date