AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

☐ **RELEASE OF INFORMATION** CLIENT NAME: _____

☐ **REQUEST FOR INFORMATION** DOB: _____

I hereby give permission to _____

To release general medical, as well as psychiatric/psychological/substance abuse (alcohol/drug), and/or HIV/AIDS information from my record to:

Name of Agency/Person: _____

Address: _____

Phone: _____

Email: _____

SPECIFIC INFORMATION TO BE ☐ OBTAINED ☐ FORWARDED is as follows:

- ☐ Psychological Evaluation
- ☐ Psychiatrist Documentation
- ☐ Treatment/Services Plan
- ☐ Lab Reports
- ☐ Discharge Summary
- ☐ Other (Explain)

Date(s) of service for which information is requested: _____

This authorization form is valid for six months from the date of signature.

Record to be used for the purpose for:

- ☐ Continuing/Coordinating Care
- ☐ Pending Court Case
- ☐ Other: _____

I understand that under confidentiality provisions only the above specified information can be released to only the above person or agency. I also understand that I may revoke this release of information at any time, providing that I notify the treating person/agency, in writing to this effect, but that revocation has no effect on action already taken.

I hereby release the treating person/agency, and the issuing person/agency, from any liability which may arise as a result of the use of the information contained in the copies of records released.

Other name(s) under which client may have been treated: _____

_____

Signature of Client: _____ Date of Consent: _____

Signature of Parent/Guardian: _____

Signature of Witness: _____