AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name:
A#:
Date of Birth:

You are hereby authorized and requested to disclose and give copies to XXX or any of its duly authorized representatives, including _____, any and all records and information concerning the undersigned which you may have in your possession, including but not limited to the following:

__ Psychological evaluation
__ Psychological history
__ Case Summary
__ Medical records
__ Ongoing communication
__ Discharge Summary
__ Telephone conversations
__ Case management plan
__ Legal information and records
__ Substance abuse treatment summaries
__ School education summaries/records
__ General information
__ Police Reports
__Other: _____

Nature and Extent of Information to be Disclosed:_____
_____

Purpose for the Disclosure:_____
_____

This consent form will expire on *(date)*_____ or _____ days from the date of service recipient signature, whichever date comes sooner.

I understand that this information is protected by law and cannot be released/requested without my written consent unless otherwise provided by law. I further understand that this consent may be revoked by me, in writing at any time, except if the information has already been released or obtained.

Service Recipient Signature: _____ Effective Date: _____

Witness/ Parent/Legal Guardian Signature (if applicable): _____

IF I DO NOT READ AND UNDERSTAND ENGLISH, THIS AGREEMENT HAS BEEN READ TO ME IN THE _____ LANGUAGE BY _____ (print name) AND I UNDERSTAND AND AGREE WITH ITS ENTIRE CONTENTS.

_____ _____
Client Signature Date