Consent for Release of Confidential Information

Client's name:_____ Date of Birth:_____

I hereby authorize _____ to release to or exchange with:

_____

The following information: (Check all that apply):

____Medical History
____Social History
____School records
____Family assessment
____Treatment plans
____ Discharge summary
____Psychological evaluation/treatment
____Psychiatric evaluation/treatment
____Chemical dependency eval/treatment
____Diagnosis, procedure codes, service dates
____Other (specify):_____

These records are required for the purpose of:

____Continued care
____Other: _____

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION, IN WRITING, AT ANY TIME AND THAT UPON FULFILLMENT OF THE ABOVE STATED PURPOSE, THIS AUTHORIZATION WILL EXPIRE. IN ANY CASE, THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE SIGNED.

_____ _____
Signature of Client or Guardian Date Signed