

**Authorization to Release
Confidential Records and Information**
(the "Records Authorization")

1. RELEASOR INFORMATION.

Name Phone #

Street Address

City, State and Zip Code

Email Address

2. RELEASEE AUTHORIZATION.

a. I hereby authorize a release of information to the following person or company:

Name of Organization Name of Contact Person

Street Address

City, State and Zip Code

Phone # Email Address

b. I authorize a release of confidential information as follows: *(Check one)*

- Release AND receive information from _____;
- To ONLY receive information from _____;

3. PURPOSE FOR DISCLOSURE.

The purpose for the disclosure is: *(Check one)*

- Further mental health evaluation, treatment, or care.
- Other Purpose: _____

Date of Treatment/Services: _____

4. INFORMATION TO BE DISCLOSED.

The following information may be disclosed: *(Check all that apply)*

- | | |
|---------------------------------------|-----------------------------------|
| _____ Intake/Discharge Summary | _____ Medical History/Assessments |
| _____ Treatment Plans | _____ Psychological Reports |
| _____ Social History | _____ Legal Information |
| _____ Educational Records | _____ Progress/Treatment notes |
| _____ Diagnostic Results | _____ Court ordered Evaluations |
| _____ Other <i>(please specify)</i> : | _____ |

Please Note: *HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here:*

- Do not release HIV-related information.
- Do not release drug and alcohol information.

5. EXPIRATION.

This Authorization will: *(Check one)*

- Will expire automatically after discharge, upon fulfillment of the purposes stated above,
- This Authorization will expire on: _____
Date Here

By signing below, I acknowledge that this request for a release of my protected confidential health information is entirely voluntary on my part. I understand that I may take back this consent at any time except for instances when action based on this consent has already been taken (such as a release or records).

I fully understand this the implications of this Authorization, the nature of the records held in my name, their contents, and the likely consequences and implications if they were to be released, and understanding and knowing this, I sign as follows:

Signature Date

If client is a minor under the age of 16, a parent/guardian must also sign:

Name of Parent/Guardian

Relationship to Minor

Signature Date