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CONSENT FOR RELEASE OF INFORMATION

NAME:
_____DOB:_____SSN:_____
I,
_____a
uthorize
(Therapist/Facility)_____
____to
RELEASE TO/OBTAIN FROM:
Therapist/Facility_____Telephone:_____
____
Address:_____City_____State_____Zip:____
____
information on the above named client pertinent to the following purpose:
_____
_____
_____
_____

The specific information to be released is:
___Intake/Discharge Summaries ___Psychological Evaluation:
___Educational Records ___Progress Notes/Treatment Plan
___Medical History and Evaluation(s)
___Developmental/Social History

For the period from _____to _____.

I understand that my records are legally protected under the Federal Confidentiality Regulations and cannot be disclosed without my written authorization except as specified in the regulations. I certify that this consent to release information has been made freely, voluntarily and without coercion and that the information provided above is accurate to the best of my knowledge. I understand that I may revoke this consent at any time, except to the extent that prior action has been taken to comply with it. Disclosure of my records by the recipient of this information may not be accomplished without my further written consent. I understand that this consent will automatically expire one (1) year from the date of signature unless I express written revocation at an earlier date.

CLIENT
SIGNATURE:_____DATE:_____

WITNESS:_____DATE:_____

PARENT OR
GUARDIAN:_____DATE:_____