

REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

I hereby authorize:

Person or facility: _____

Address: _____ Phone: _____

to exchange information from records about _____ Date of Birth _____

with

Person or facility: _____

Address: _____ Phone: _____

The purpose(s) of this release is:

- Further mental health evaluation, treatment, or care
- Treatment planning
- Other: _____

The information to be disclosed:

- Medical history and evaluation(s)
- Mental health evaluations
- Developmental and/or social history
- Educational records
- Progress notes, and treatment or closing summary
- Other: _____

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed, or upon fulfillment of the purposes stated above.

Signature of client or parent _____

Printed name _____

Date _____