AUTHORIZATION TO RELEASE AND/OR OBTAIN INFORMATION CONSENT FORM

I, _____, will authorize
(CLIENT NAME)

_____
(NAME OF COUNSELOR)

to ____release to and/or ____obtain information from:

_____
(NAME OF INDIVIDUAL, HOSPITAL, OR AGENCY WHO WILL RECEIVE/RELEASE INFORMATION)

_____
(ADDRESS)

_____
(PHONE NUMBER, FAX NUMBER, E- MAIL ADDRESS)

Information to be released includes (Please INITIAL each item to be released):

_____ ALL INFORMATION including medical, psychiatric, psychological, HIV/AIDS, alcohol, drug or other substances.
_____ Specific information/reports, such as: (Please INITIAL each item to be released)
____ Treatment/Discharge summary ____ Physical/laboratory results
____ Clinical/psychiatric/psychological assessment ____ Progress Notes
_____Verbal exchange of information. Please specify: _____
_____Other:_____
Specific purpose for disclosure of information:_____

This information cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time (except to the extent that action has been taken) by written notification to the Counselor named above. If I DO NOT revoke this authorization, it will expire automatically in 365 days.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Therapist/Witness: _____ Date: _____