KIM CASTRO CONSULTING, LLC

KIMBERLY CASTRO OWENS
MSCM, MAC, CAADC, CACII, CCS
806 Old Mill Trail
Ball Ground, GA 30107

AUTHORIZATION TO RELEASE CLIENT INFORMATION

RE: _____

I hereby authorize Kimberly Castro of Kim Castro Consulting, LLC, at 806 Old Mill Trail, Ball Ground, GA 30107 to release specified information in my treatment record to _____. This data shall include only that of the nature and to the extent which is specified below:

( )	Face Sheet	( )	Current Medications
( )	Discharge Summary	( )	Care Plan
( )	History and Physical	( )	Telephone Calls/Verbal Communication
( )	Psychiatric Evaluation (Data Base)	( )	Laboratory Reports
( )	Psychological Evaluation	( )	X-Ray reports
( )	Social History	( )	Consultations
( )	Initial Clinical Assessment	( )	Academic Achievement and Behavior
( )	Reason for Referral	( )	Legal Documents
( )	Alcoholism or Drug Abuse	( )	History of Psychotropic Drugs

(X) Other (please specify): Entire Chart excluding psychotherapy notes, unless requested by client

I understand this information will be used only for SUPPORT OF THE NEED FOR SERVICES TO FACILITATE AND COORDINATE DELIVERY IN THE BEST INTEREST OF THIS CLIENT. I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand the contents to be released and the need for the information. I hereby acknowledge that this consent is truly voluntary. I also understand that I may revoke (by written notice) this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

Termination of Treatment

(Specification of the date, event, or condition upon which this consent expires)

_____ _____

CLIENT DATE

_____ _____

WITNESS DATE

_____

DATE OF BIRTH