AXIS HOPE, LLC
Hope is the best medicine.

Axis Hope, LLC

Mental Health Clinic for Children & Adolescents
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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to Axis Hope by other individuals or agencies. Such requests should be referred to the original individual or agency.

I _____ authorize Axis Hope to:

_____ release to:
_____ obtain from:
_____ exchange with:

_____
_____
_____
_____

the following information pertaining to the patient/DOB:_____

_____ treatment summary
_____ history/intake
_____ diagnosis/psychological assessments
_____ laboratory results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ all records related to mental health
_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____ _____.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ Date:_____
Signature of Client (if applicable)

_____ Date:_____
Signature of Parent