Evergreen Clinical Associates
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evergreenclinicalassociates@gmail.com

AUTHORIZATION FOR RELEASE OF INFORMATION

NOTE: All matters related to *Client Records* are considered privileged and confidential and are treated as such by Evergreen Clinical Associates / Shawn E. Conn, MSW, LCSW. Release of any information cannot be given without the consent of the client/guardian.

_____ is hereby granted my permission to release to Evergreen Clinical Associates / Shawn E. Conn, MSW, LCSW such information as may be necessary regarding treatment of the Client listed below:

Name of Client	Date of Birth	Social Security Number

PURPOSE OR NEED FOR DISCLOSURE:

SPECIFIC INFORMATION TO BE DISCLOSED:

- ☐ Treatment History
- ☐ Date of Admission
- ☐ Date of Discharge
- ☐ Medical History
- ☐ Social History
- ☐ Legal Status
- ☐ Psychological
- ☐ Evaluations
- ☐ Welfare Care Number
- ☐ Comprehensive Physical
- ☐ Examination Results
- ☐ Other

This consent to disclose may be revoked by me at any time except to the extent that the action has been taken in reliance thereon. The consent (unless expressly revoked earlier) expires on:

_____

(Specific Date, Event, or Condition upon which it will expire)

As required by section 2.32 (a) Prohibition on Redisclosure Rules. "This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR, Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose."

_____

Signature of Client/Client Guardian

_____ _____

Date Signed Witness