RELEASE OF INFORMATION

Release Information Regarding:

Client: ______________________________

Social Security Number: ______________

Date of Birth: ________________________

Release Information to/from:

Name: ________________________________

Address: ______________________________

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Phone: _______________________________

Phone: _______________________________

Nature of Relationship to Client: ____

Purpose: The purpose of this disclosure of information is to improve assessment and treatment planning. The sharing of information is relevant to treatment and when appropriate, to coordinate treatment services and continuing care planning. If for other purposes please specify:

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Revocation: I understand I have the right to revoke this authorization in writing at any time. I further understand that a revocation of the authorization of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Information which can be disclosed (please initial):

___ Demographic Information
___ Initial assessment & Recommendations
___ Diagnoses
___ Clinical Summary
___ Treatment Plan
___ Medication Management Information
___ Psychological Evaluation and Notes
___ Other: ___________________________
___ Progress in treatment
___ Progress Notes
___ Discharge/Transfer Summary
___ Continuing Care Plan
___ Presence in treatment
___ Emergency Contact
___ Education Information

Expiration: Unless sooner revoked, this consent expires one year from the date of the end of treatment, unless otherwise indicated:

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Upon my request, I understand that I will be given a copy of this authorization for my records. Note: if signature not witnessed by staff, document must be notarized or presented a copy of a valid photo I.D. with signature.

Signature of Client: ____________________________________ Date: ____________________

Signature of Guardian: __________________________________ Date: ____________________

Signature of Staff: ______________________________________ Date: ____________________