****

**Client Consent & Disclosure of Information**

*Release of Information (ROI)*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby

(Client, Parent or Guardian if client under the age of 13)

authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Name of Therapist/Agency)

To disclose to:

(Name of Person, Government, Medical Agency, Other Parties)

(Address and Telephone Number)

The following specific information: (i.e. psychiatric evaluation, treatment information, diagnosis)

I am aware of and expect that all information shared is protected and remains confidential by Nhautrey Brown, MSW, LICSWA, the agency requesting and receiving information and by State and Federal regulations.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Client, Parent/Guardian Signature if kid under age of 13) (Date)

Updated August 2021