

Regan Hager LMHC
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AUTHORIZATION FOR RELEASE OF INFORMATION

Client: _____ SSN: _____ DOB: _____

Authorized Consultant: Regan Hager LMHC

I certify that I am the patient or person authorized to consent for patient. I hereby authorize representatives from the following agencies/programs to engage in verbal, written, or electronic communication on behalf of myself (or client if minor) with the specific provider named above. I am aware that the information exchanged will be used for professional purposes in the development of a treatment plan and that the information will be considered strictly confidential. Therefore, I release all agencies/professionals involved from any legal liability that may arise from this transfer of information. Any information obtained is for the sole use of this agency and shall not be re-released. Please check one box per form.

- | | |
|---|--|
| <input type="checkbox"/> Lakeview Center, Inc. | <input type="checkbox"/> DCF |
| <input type="checkbox"/> Children's Home Society | <input type="checkbox"/> Escambia County Schools |
| <input type="checkbox"/> Lutheran Services | <input type="checkbox"/> Santa Rosa County Schools |
| <input type="checkbox"/> Families First Network (FFN) | <input type="checkbox"/> Okaloosa County Schools |
| <input type="checkbox"/> Avalon Center, Inc. | <input type="checkbox"/> DJJ |
| <input type="checkbox"/> Bridgeway Center, Inc. | <input type="checkbox"/> Guardian Ad Litem Program |
| <input type="checkbox"/> COPE Center, Inc | |
| <input type="checkbox"/> Children's Medical Services | |
| <input type="checkbox"/> Private Physician: _____ | |
| <input type="checkbox"/> Private Hospital: _____ | |
| <input type="checkbox"/> Other: _____ | |
| <input type="checkbox"/> Private Agency: _____ | |

TYPE OF INFORMATION TO BE EXCHANGED

Check all that apply

- | | |
|---|---|
| <input type="checkbox"/> School Records/Testing | <input type="checkbox"/> Speech/Language Evaluations |
| <input type="checkbox"/> Health and Medical Records | <input type="checkbox"/> Psychological Evaluations |
| <input type="checkbox"/> Psychiatric Evaluations | <input type="checkbox"/> Psychosocial History/Reports |
| <input type="checkbox"/> DCF Records and Reports | <input type="checkbox"/> Mental Health Records |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Attendance/Progress Summary |

The above includes, but is not limited to, available verbal and written information regarding: past and present functioning in school, community, and residence; review and results of previous interventions; past and present living environment and the impact of this on the client's current functioning and capacity to benefit from intervention. This information will be discussed and reviewed by members of the client's specific Multi-Disciplinary staffing as part of the Mental Health therapeutic process.

This authorization will remain in effect for one (1) year from the date of my signature. I understand that I may withdraw this authorization at any time by written notification to the assigned Mental Health consultant.

Mental Health Counselor, Regan Hager LMHC: _____ Date: _____

Signature of Patient or Person Authorized to consent for patient: X _____ Date: _____