Family Ties Mental Health Counseling Services

Consent to Release

Date: _____

I authorize: _____
(School, Primary Care, DSS, Hospital, etc.)

Address: _____

To release information for: _____ DOB: _____

To: Family Ties and independent providers.

Please **initial** information to be given:	Please **initial** specific Information:
_____Verbally _____In Writing _____By Fax _____Electronically (HIPPA Compliant)	_____Assessments/Evaluations _____Treatment Plans/Plan of Care _____Crisis Plan _____Progress Notes _____Discharge Summary _____Other (Specify)_____

This consent is specifically for coordination of care, and is valid until (may not exceed one year): _____

I understand information released regarding my treatment may include information pertaining to psychiatric treatment, drug abuse, and/or alcoholism (per Federal Law 42 CFR Part 2), acquired immunodeficiency syndrome (AIDS) or Human Immunodeficiency Virus (HIV).
The information herein disclosed is from records whose confidentiality is protected by regulations (APSM 45-1- State Confidentiality Rules) which prohibits anyone from making further disclosure without specific written client consent, or as otherwise permitted by such regulations.
I, the undersigned, authorize release of the above information to the person(s) or agencies listed below I understand that I have the right to refuse to sign this consent, as well as the right to withdraw my consent to release information at any time, except to the extent that action based on this consent has been taken. I understand that revocation of this authorization must be submitted in writing to the Regional Director of Family Ties of Brunswick, LLC. Furthermore, I understand that eligibility and/or receipt of services is not contingent upon signing this release or revoking this release.

Parent/Legal Guardian Signature_____ Date_____

Consumer Signature_____ Date_____

Witness Signature_____ Date_____