FAMILY CARE PSYCHIATRY

RELEASE OF INFORMATION/RELEASE OF CONFIDENTIALITY to Family/Friend

Client's name:
Client's address:
Client's date of birth:
Phone number:

I AUTHORIZE FCP RELEASE THE FOLLOWING TO THE PARTY LISTED BELOW

I authorize FCP to release information contained in my medical records including alcohol and drug abuse records protected under Code 42 of Federal Regulations, Part 2, (if any), mental health records, psychiatric records, including communications made be me to

Name of Person:

Relationship:

Address:
Suite:
City:
State:
Zip Code:

REVOCATION CLAUSE / SIGNATURE
This consent may be revoked at any time. FCP is not responsible for information released prior to revocation. I understand that in order to revoke this authorization, I may do so verbally (in person, over the phone) or in writing.

Client Signature:

Parent or Legal Representative Signature:

Date:

Witnessed By:

Date:

*** This Release expires 6 months after client's discharge from FCP ***