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Request/Authorization to Release Confidential Records and Information

I hereby authorize:

Person or Facility:____

Address:____Phone:_____________________

____

To exchange verbal/written information from records or other sources about

____, born on _________________________

With:

Person or Facility:____

Address:____Phone:_____________________

____

For the following purpose(s):

- ☐ Further mental health evaluation, treatment, or care
- ☐ Treatment Planning
- ☐ Other:____

This release is valid until ____

The information to be disclosed is marked by an (X) in the boxes below:

- ☐ Medical history and evaluation(s)
- ☐ Mental health evaluations
- ☐ Developmental and/or social history
- ☐ Educational records
- ☐ Progress notes and treatment summary
- ☐ Neuropsychological report
- ☐ Other (specify):____________________________________

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their consents, and the consequences and implications of their release. This request is voluntary on my part and I understand I can rescind this consent at any time with the exception to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed, or upon total fulfillment of the purposes stated above.

Signature of client (12 years or older)	Printed Name of Client	Date
Signature of Parent	Printed Name of Parent	Date
Signature of Witness	Printed Name of Witness	Date