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REQUEST AND AUTHORIZATION TO RELEASE RECORDS AND INFORMATION

I,____
Print Name of Client SS# DOB

I,____
Name of Parent/Guardian/Legal Representative SS# DOB

hereby authorize the following mental health professional: ____________________________to **disclose and obtain** the following checked information from my/child's clinical records between the dates of ______________and__________________.

0 Intake Summary
0 Psych Evaluation/Diagnosis
0 Psych Testing
0 Family History (clinical/substance use)
0 Social History
0 Discharge Summary
0 Treatment Summary
0 HIV testing

To/From
Name______________________________________Phone/Fax__________________________
Address____

This authorization/request to release/obtain information from the above-named records is understood as to the nature of the records and information, implications of its release, and is made voluntarily on my part. I understand that I may revoke this consent to release information at any time except to the extent that action based on this consent has been taken. The cancellation of this consent must be in writing, signed and is effective from the date it is received by this therapist.
I further understand that this release of information expires in 180 days from the date this Release of Information is signed, unless otherwise indicated in writing by the client.

Client/Parent/Guardian/Legal Rep___________________________________Date__________
Witness_____________________ ______________________________________Date__________