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Request/Authorization to Release Confidential Records and Information

Source of Information

Person or Facility _____
Address _____
_____
Phone _____

A. Identifying information about me/the patient
   Name _____
   DOB _____
   Address _____
   _____
   Phone _____
   Parent/Guardian (If applicable) _____
   Address and phone of parent/guardian (if different than above)
   _____
   _____
   _____

B. I hereby authorize the source named above to send, as promptly as possible, the records listed below marked by an X. The items not to be released have a line drawn through them. Page numbers are indicated where appropriate.
   ___Start of outpatient treatment: _____ End of treatment: _____
   ___Psychological evaluation (s) or testing records, and behavioral observations or checklists completed by any staff member or by the patient.
   ___Psychiatric evaluations, reports, or treatment notes and summaries.
   ___Treatment plans, recovery plans, aftercare plans.
   ___Admission and discharge summaries.
   ___Social histories, assessments with diagnoses, prognoses, recommendations and all similar documents.
   ___A letter containing dates of treatment (s) and a summary of progress.
   ___Other: _____

C. I authorize the source named above to speak by telephone with the therapist identified in part K about the reasons for my/the patient's referral, any relevant history or diagnoses, and other similar information that can assist with my/the patient's treatment or being evaluated or referred elsewhere.
D. I understand that no services will be denied me/the patient solely because I refuse to consent to this release of information, and that I am not in any way obligated to release these records. I do release them because I believe they are necessary to assist in the development of the best possible treatment plan for me/the patient. The information disclosed may be used in connection with my/the patient's treatment.
E. This request/authorization to release confidential information is being made in compliance with the terms of the Privacy Act of 1974 (PL 93-579) and the Freedom of Information Act of 1974 (PL 93-502); and pursuant to the Federal Rule of Evidence 1158 (Inspection and Copying of Records upon Patient's Written Authorization). This form is to serve as both a general authorization and a special authorization to release information under the

Drug Abuse Office and Treatment Act of 1972 (PL 92-255), the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act Amendments of 1974 (PL 93-282), the Veterans Omnibus Health Care Act of 1976 (PL 94-581), and the Veterans Benefit and Services Act of 1988 (PL 100-322). It is also in compliance with 42 C.F.R. Part 2 (PL 93-282) which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

F. In consideration of this consent, I hereby release the source of the records from any and all liability arising thereform.

G. This request/authorization is valid during the pendency of any claim or demand made by or on behalf of me/the patient, and arising out of an accident, injury or occurrence to me/the patient. I understand that I may void this request/authorization, except for action already taken, at any time by means of a written letter revoking the authorization and transfer of information, but that this revocation is not retroactive. If I do not void this request/authorization, it will automatically expire in 90 days from the date I signed it.

H. I agree that a photocopy of this form is acceptable, but it must be individually signed by me, the releaser, and a witness, if necessary.

I. I affirm that everything in this form that was not clean to me has been explained. I also understand that I have the right to receive a copy of this form up on my request.

J. Signatures

_____	_____	_____
Signature of Client	Printed Name	Date

_____	_____	_____	_____
Signature of parent/ guardian/representative	Printed name	Relationship	Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____	_____	_____
Signature of witness	Printed Name	Date

K. I, a mental health professional, have discussed the issues above with the patient and/or his or her parent or guardian. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____	_____	_____
Signature of Professional	Printed Name	Date

Copy for patient or parent/guardian Copy for source of records Copy for recipient of records