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AUTHORIZATION FOR RELEASE OF INFORMATION

For: _____ **D.O.B.** _____

Parent/Guardian (if nec.) _____

Disclose Information and/or **Obtain information**

TO/FROM:

Name: _____

Organization: _____

Address: _____

Telephone: _____

Type of information to be disclosed/obtained:

- My entire Mental Health Record Treatment Plan and recommendations
- Diagnosis/ Assessment Progress Notes Substance Abuse Records

Specifics of information requested: _____

Form in which information can be released:

Written Verbal Photocopied ther: _____

I may revoke this consent at any time except to the extent that action has been taken in reliance to it. If I do not revoke it this consent will expire one year after I have terminated treatment.

Signature of Client: _____

Date: _____

Parent or Guardian: _____

Date: _____

Witness: _____

Date: _____