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Consent to Release / Request Confidential Information

Client Name:	Client Date of Birth:

I authorize ( ) Release and/or ( ) Request the following information from/to :

Recipient:	Organization:
Recipient Address/Email:	
Recipient Phone/Fax:	Relationship to Client:

Purpose of disclosure/Why information is required: Continuity of Care

I authorize the following information to be released in verbal and /or written form:

☐ Diagnosis	☐ Attendance/Participation Dates	☐ Intake Paperwork
☐ Treatment Plan	☐ Therapy Progress Notes	☐ Psychiatric Progress Notes
☐ Psychiatric Evaluation	☐ Psychological Testing	☐ Biopsychosocial Assessment
☐ Discharge Summary	☐ Other:	

I understand that my records and/or those of any individual(s) listed above are protected under federal and state confidentiality regulations. I understand that if I have authorized the release of substance use disorder information that the confidentiality of this information is protected by federal law (HIPAA and 42 CFR Part2). This information cannot be disclosed or re-disclosed without my written consent, unless otherwise specifically provided for in the regulations. I understand that I may revoke this consent at any time except to the extent that the information has already been released. I understand and agree that this release form may be sent to the agencies and persons identified above. Regarding information not pertaining to a substance use disorder, a disclosure authorized by me carries with it the potential for re-disclosure by the recipient and that federal privacy laws may no longer protect that information.

This authorization will expire 365 days from this day or __/__/__, unless revoked earlier in writing by me. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in release of it. I hereby release the above parties from any liability, which may result from furnishing this information.

_____ _____
Client Date

_____ _____
Parent/Guardian/Custodian (if client is under 15 y/o) Date

_____ _____
Therapist Date

A facsimile/photocopy of this release shall be considered as valid as the original