**Authorization for the Release of Information**

**Client Name:** _____ **Date of Birth:** _____

*I.* _____ *authorize* _____. *to disclose and receive information relevant to my care and treatment with the individual named below:*

**Person to whom information may be released:** _____

**Address:** _____

**Phone:** _____ **Fax:** _____

**Information Authorized to be Released (Please check all that apply):**

___Information pertaining to Scheduling, Billing, and Administrative Concerns

___Diagnosis, Treatment Plan, and Progress

___Bio-psychosocial History and Background

___Information pertaining to Substance Use

___Information pertaining to HIV/AIDS

___Copy of Testing and Assessment Records

___Copy of Complete Medical Record

___All of the Above AND Any and All Information Requested

*I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has already been taken. This consent shall expire 90 days after the date of client discharge unless another date is specified.*

*To the party receiving this information: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of medical or other information is not sufficient for this purpose.*

**Signature of Client/Parent/Legal Guardian:** _____

**Date on which information may be released:** _____

**Date on which authorization is revoked (OPTIONAL):** _____