Consent for Release of Information

I hereby authorize _____ to release information from the records of

_____ D.O.B. _____.

☐ *By checking this box I authorize information to be exchanged freely by both parties identified in this release*

The information to be released is:

Psychiatric Evaluation ___
Medical History ___
Social History ___
Discharge Summary ___
Course of Treatment ___
Lab Reports ___
Medications ___

Developmental History ___
Academic/School Records ___
Attendance Records/Appointments ___
Teachers/Counselors Comments ___
Complete Behavioral Checklist ___
Recommendations ___
Psych/Achievement Tests ___

Other (specify): _____

Records are requested for the purpose of: _____

(Please note: HIV, Mental Health, and Drug and Alcohol information contained in this consent will be released unless indicated.)

Do not release:

Mental Health _____ HIV _____ Drug and Alcohol _____

I understand that this authorization is effective for a period of one year from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the person I authorized above to release the information. If applicable, specify other expiration date here.

Signature:_____ Date: _____

Please forward Information to:

Name of person/facility: _____

Address: _____

Phone/Fax Number: _____

I have been told that in order to protect the limited confidentiality of records, my agreement to obtain or release is necessary and this permission is limited for the purposes and to the person listed above, and will be effective during the date listed below. I also understand that this consent is revocable except to the extent which records have been sent.

This consent shall be in effect from: _____ until _____

Patient Signature: _____ Date: _____

Legal Guardian Signature: _____ Date: _____

Authorized Representative Signature: _____ Date: _____

Oral Consent (NOT VALID FOR D&A!!) Dated: _____

Authorized Representative Signature: _____

Authorized Witness Signature: _____