



AUTHORIZATION TO RELEASE / OBTAIN MEDICAL, PSYCHIATRIC, ALCOHOL, SUBSTANCE USE RECORDS, HIV RELATED INFORMATION

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MI:	NICKNAME:
DATE OF BIRTH:	SOCIAL SECURITY NUMBER:		
HOME ADDRESS:	CITY:	STATE:	ZIP:
PHONE NUMBER:	ADDITIONAL INFORMATION:		

***I HEREBY AUTHORIZE AND REQUEST THE CLINIC FOR MENTAL HEALTH AND WELLNESS MAY RELEASE/REQUEST THE FOLLOWING:**

<input type="checkbox"/> ALL INFORMATION	
<input type="checkbox"/> SUBSTANCE ABUSE EVALUATION	<input type="checkbox"/> MEDICATION TREATMENT NOTES
<input type="checkbox"/> CLINIC VISIT NOTES / PSYCHOTHERAPY NOTES	<input type="checkbox"/> PSYCHIATRIC EVALUATION
<input type="checkbox"/> NEUROPSYCHOLOGICAL / PSYCHOLOGICAL EVALUATION	<input type="checkbox"/> INPATIENT TREATMENT RECORDS
<input type="checkbox"/> OUTPATIENT TREATMENT RECORDS	<input type="checkbox"/> TREATMENT PLAN
<input type="checkbox"/> DISCHARGE SUMMARY	<input type="checkbox"/> ACADEMIC OR EDUCATIONAL RECORDS
<input type="checkbox"/> CLINICAL LABS, SLEEP STUDY, MEDICAL INFORMATION	<input type="checkbox"/> OTHER

*** TO THE FOLLOWING PERSON/AGENCY***

NAME:			
FACILITY:			
ADDRESS:	CITY:	STATE:	ZIP:
PHONE NUMBER:	FAX NUMBER:		

INFORMATION MAY BE: (PLEASE INITIAL)

<input type="checkbox"/> RELEASED TO THE CLINIC FOR MENTAL HEALTH & WELLNESS	<input type="checkbox"/> OBTAINED FROM THE CLINIC FOR MENTAL HEALTH & WELLNESS
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(I AM AWARE THAT THESE DOCUMENTS WILL CONTAIN VERY DETAILED, SENSITIVE, INFORMATION ABOUT MYSELF OR THAT OF MY CHILD, INCLUDING: FAMILY HISTORY; LEGAL HISTORY; SOCIAL HISTORY; MEDICAL HISTORY; AND TREATMENT HISTORY)

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except in the event that the action has already been taken. Subsequent disclosure of my medical records by those receiving the authorized information is prohibited. I hereby release both the above parties from any liability which may result from furnishing the information released or requested. I have read the above and acknowledge that I understand the terms and conditions of this authorization.

Without my expressed **written** revocation, this consent will **expire in ONE (1) YEAR from date signed, or on this date:** _____

CLIENT'S SIGNATURE or PARENT (if minor)

DATE:

ORAL CONSENT "I understand the nature of the release and freely give oral consent" / **Staff Witness**

DATE:

AUTHORIZED PERSON'S NAME / SIGNATURE IN LIEU OF PATIENT:

DATE:

POWER OF ATTORNEY GUARDIANSHIP ORDER