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Request/Authorization to Release Information

I hereby authorize:

Person or facility:

____

____

____

Address:

____

____ Phone:

____

to release information about ____, born on _____________ , and whose Social Security number is ____, for the following purpose(s):

❑ Treatment planning ❑ Continuity of Care ❑ Other: ____

These records/information concern the time between _____10/15_______ and ______10/16___________.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

____ __________________________________

____

Signature of client Printed name Date

_______________________________________ _____________________________ ____________

____

Signature of parent/guardian/representative Printed name Relationship Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

____ ___________________________________

____

Signature of witness Printed name Date