## CONSENT FOR RELEASE OF INFORMATION

Client Name ___________________________ DOB ___________ SSN ______________________

Address _____________________________________________________________________________

Name/Address of Person or Organization **Disclosing** Information

______________________________________________________

______________________________________________________

______________________________________________________

Name/Address of Person or Organization **Receiving** Information

______________________________________________________

______________________________________________________

______________________________________________________

Extent/Nature of Information to be Disclosed (be as specific as possible, e.g. discharge summary)

____________________________________________________________________________________

____________________________________________________________________________________

Purpose or Need for Information:

____________________________________________________________________________________

____________________________________________________________________________________

*I hereby authorize the release of the above information from my records. I understand that the information to be released from my records is confidential and protected from disclosure. I understand that my consent to release this information will expire in one year from this date. I also understand that I have the right to cancel my permission to release this information at any time before it is released.*

Client Signature __________________________________________________ Date ______________

*If parent or guardian, indicate relationship to client*

Signature of Witness _______________________________________________ Date ______________

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