## Authorization for Release of Information

*To our Clients:* We are better able to serve you and work with other agencies that know you and your family. By signing this form, you are giving permission for these organizations to share information about your situation.

**NAME:** _____ **D.O.B.** ___/___/___ **ID#** _____

**I authorize the following individuals/agencies:** **Anger Solutions**

**BEND, OREGON 97701**

**To provide information to:**

_____ _____

**NAME** **ADDRESS/PHONE NUMBER**

Including records of:

● Yes _____ No Family History Other, as listed: Anger Management

● Yes _____ No Domestic Violence _____

Domestic Violence Record include all aspects of History of Violence, alcohol/drug risk factors, assessment of current risk to Victim/Partner and others.

I agree that the agencies and individuals listed above may share and exchange information about my family and my circumstances.
● Yes _____ No

Purpose: The information received will be used to evaluate my situation and to plan for and coordinate services for me and my family, or for other purposed specified: _____

**This permission is good for one year or until: REVOKED IN WRITING**

**I can cancel this at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by State and Federal Law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.**

**CLIENT SIGNATURE:** _____ **DATE:** _____

To those receiving information under this authorization: This information disclosed to you is protected by State and Federal Law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.