Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_             DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*By signing below, I give my permission to Beth Miller, LCSW to release and/or receive*

*my/my child’s confidential information to/from:*

Name of Facility/ Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*I authorize the release of the information listed below, which requires specific consent under law. (you must initial all that apply).*

  \_\_\_\_ Mental Health \_\_\_\_\_  Substance Abuse

\_\_\_\_   HIV/AIDS Related

*I authorize the following information to be released, shared and exchanged. (you must initial all that apply).*

\_\_\_\_    Diagnostic Evaluation/Intake

\_\_\_\_ Progress Notes

\_\_\_\_    Discharge Information

\_\_\_\_    Other, specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*The purpose of the release of this information is for:*

\_\_\_\_    Continuation of Care \_\_\_\_\_    Insurance

\_\_\_\_ Attorney/Legal   \_\_\_\_\_    School

\_\_\_\_ Disability/Eligibility \_\_\_\_\_    Personal Reasons

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_             DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Please initial each of the following statements and sign at the bottom.*

\_\_\_\_\_ *I understand that my information may not be protected from re-disclosure by the requester/recipient of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations (CFR 42, part 2), and the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”), 45 CFR, part 160 & 164, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.*

\_\_\_\_\_ *I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment for services.*

\_\_\_\_\_ *I understand that if I fail to specify an expiration date or condition this authorization is valid for a period of one year from the signature date. I also understand that I may revoke this authorization at any time. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.*

*I have read the above agreement and I consent to release of information as outlined above.*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Date Signed Expiration Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Legal Representative Date Signed Expiration Date

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Complete the following ONLY if you wish to revoke the authorization:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, am revoking this consent to release information,

effective \_\_\_\_/ \_\_\_\_/ \_\_\_\_\_.