AUTHORIZATION FOR RELEASE OF PSYCHIATRIC/MEDICAL RECORDS

NAME: DATE OF BIRTH:

This authorization is for use or disclosure of psychiatric/medical information, including diagnosis and treatment of mental disorders and/or conditions related to alcohol/drug abuse.

RELEASE TO:

(Program Name, Address and Program Director's Name)

I hereby authorize the following person/agency to furnish the above named recipient with the records and information listed below:

☐

The recipient may use the information authorized only for the following purposes:

☐

This authorization shall remain in effect until .

Date

I understand that I may revoke this authorization at any time, except to the extent that the person/agency has already acted in reliance on it.

I understand that the recipient may not further use or disclose this information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

I further understand that I have a right to receive a copy of this authorization upon my request.

Information Requested:

Medical Examination ☐

Psychological Evaluation ☐ Psychiatric Evaluation ☐

Other

Authorizing Participant Signature Date

Authorized Program Representative Date

Client Log #: _____