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CONSENT TO RELEASE/RECEIVE INFORMATION

I hereby authorize

_____

_____

_____

to release/receive information and/or records regarding:

_____DOB_____
(Name of person(s) whose records are to be release/or information to be shared.)

Data to include the following:

☐ psychological evaluation
☐ psychotherapy/counseling records
☐ treatment summary
☐ discharge summary
☐ artwork
☐ educational records
☐ personal references
☐ medical records
☐ legal/court records
☐ other_____

The disclosure of records authorize herein will be used for:

☐ diagnostic evaluation
☐ court evaluation
☐ educational advocacy
☐ psychotherapy
☐ custody/visitation
☐ other_____

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance thereon, and, if not earlier revoked, it shall terminate without expressed revocation on_____. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization and do not need to sign this form to ensure treatment. I understand that any disclosure of information carries the risk of potential for an unauthorized disclosure, and the information may not be protected by federal confidentiality rules. If I have any questions about disclosure of my health information, I can discuss it at any time. A photocopy of this signature shall be considered as valid as the original. I have read, fully understand, and agree to the above.

_____

signature printed name date relationship