AUTHORIZATION OF RELEASE OF RECORDS OR INFORMATION

I,(nar hereby give permission to [program name] to release information	me of client), DOB/	
☐ 14A-2 District Court		
Circuit Court		
Juvenile Court		
Address of i	Individual/Agency	
11 Cas of 1		
City State	Zip Code	
	2.0	
Area Code Phone Number		
My entire record; (initial OR)		
Only the following info	rmation (initial all that apply):	
	☐ Treatment Plan	
⊠ Treatment Recommendations	☐ Name of new treatment provider	
⊠ Expected length of treatment	Other Evaluation (Specify)	
△ Attendance Records		
⊠ Progress Report of my treatment	Diagnosis	
	Other (Specify):	
	ould be released (initial bold options):	
⊠ Verbal		
☑ Written ☐ Photography		
☐ Video		
☑ Other: Electronic I authorize staff to communicate by n	neans of E-mail, fax and cordless or cellular telephones, where	
the use of these means is expedient or timely.		
The man of the desired	in a committee of the state of	
 Ine purpose of this disclosure ⊠ Continuity of care 	is to permit (initial at least one):	
☐ Case management		
Reimbursement/processing of benefit claims		
□ Other:		
I understand that my records may contain protected informat HIV/AIDS virus, other sexually transmitted diseases, drug/al health care and diagnosis.	ion regarding diagnosis and/or treatment for : cohol diagnosis and/or treatment and/or psychiatric or mental	
Please initial the statements that apply:		
I give consent to release my HIV (AIDS virus) diagnosis/treatment information		
I give consent to release my drug/alcohol/substance diagno		
I give consent to release my psychiatric diagnosis/treatment to		

The timeframe within which this release of information is applicable is (initial one option):			
a period not to exceed one year from the date this is signed			
a time period from to			
an event (describe event:) Completion of the [program name] and/or 90 days after Discharge from [program name]			
*If more than one box is checked, the authorization will expire by whichever time period/event is sooner.			
I may revoke this consent at any time by contacting [program name] except to the extent that action has been taken in reliance upon it.			
I understand I have the right to receive a copy of this authorization form.			
Signature of Client	Date		
	_		
Signature of Witness/Notary	Date		