FAMILY CENTERED THERAPY & PROVIDER SUPPORTS

Authorization for Release of Information

Date: _____ Date of Birth: _____ SSN: _____

I, _____, do hereby consent to and authorize Family Centered Therapy & Provider Supports to, as indicated to,

□ obtain from: □ release to: □ exchange oral information with:

_____,
Name of Person at Facility | Facility/Organization | Address, City, State, Zip | Phone

_____,
Name of Person at Facility | Facility/Organization | Address, City, State, Zip | Phone

_____,
Name of Person at Facility | Facility/Organization | Address, City, State, Zip | Phone

for the authorized information pertaining to _____.
Client

The Information to be:

Obtained	Released		Obtained	Released	
□	□	Presence in treatment. (including admission and discharge dates)	□	□	Medical history and physical examination.
□	□	Treatment Plan	□	□	Medication Record
□	□	Diagnosis, brief description of progress and prognosis	□	□	Physician's orders
□	□	Psychological tests or projective assessments	□	□	Lab, X-ray, EKG
□	□	Progress Notes	□	□	Medical discharge summary
□	□	Consultations	□	□	Educational records including achievements and assessments. (IEP information, discipline records, school attendance.)
□	□	Legal Information (police reports)			
□	□	Crisis Screening report	□	□	Evaluations
□	□	Custody Evaluation	□	□	Substance abuse reports including UA results
□	□	Other:_____			

Information is Needed for the Following Purposes:

□ To provide ongoing treatment/continuity of care.
□ To provide educational services/ school placement or assessment/ coordination of services with authorized school officials
□ Legal Proceedings
□ Disability Determination
□ To coordinate treatment efforts with my family/concerned person
□ To coordinate treatment and continuing care efforts with my employer.
□ To enable judges, attorneys, probation/parole officers to support treatment goals or make legal decisions on my behalf (Diversion, Probation, Parole)
□ Other:_____

READ CAREFULLY: I understand that my medical/behavioral health records are confidential. I further understand that by signing this authorization, I am allowing release of information to the agency or person specified above. Drug and/or alcohol abuse information records are specifically protected by federal regulations. By signing this authorization, I am allowing the release of all records above, including any drug and/or alcohol information to the agency or person specified above. Federal Regulations prohibit the recipient of the information from making further disclosure without the specific, written consent of the responsible person, or as otherwise permitted by law or regulation. A general authorization for the release of medical or other information is not sufficient for this purpose. This consent may be revoked at any time except to the extent that action has already been taken. This authorization automatically expires 90 days after discharge. This authorization to release information is subject to the following restrictions:_____

_____ _____
Signature of Client Date

_____ _____ _____
Signature of Parent, Guardian or Legal Representative Relationship to Client Date

_____ _____
Signature of Witness Date