**Authorization to Release Confidential Records and Information**

**Patient Name: Date of Birth:**

**Patient Address:**

I, **hereby authorize:** (Print your name and date of birth)

**To:** ☐**Release** ☐**Receive** ☐ **Exchange**

**The following protected health information:**

☐Intake and discharge summaries ☐Medical history and evaluation(s)

☐Mental health evaluations ☐Developmental and/or social history

☐Progress notes ☐Educational records

☐Other:

**To/From: Phone Number:**

(Print the name of the person or facility)  **Fax number:**

**Address:**

**For the following purpose(s):**

☐Further mental health evaluation, treatment, or care ☐Rehabilitation program development or services

☐Treatment planning ☐Research ☐Other:

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 365 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

 Printed Name (Patient) Signature Date

 Printed Name (Parent/Guardian) Signature of Parent/Guardian Date

 Printed Name (Witness) Signature of Witness Date