Consent to Release and Obtain Records

Client Name: _____ Birthdate:_____

☐ I authorize the release of information concerning the said client to the following:

☐ I authorize this provider to obtain information concerning said client from the following:

Name/Agency: _____

Address: _____

_____

City *State* *Zip*

Telephone: (_____)_____ **Fax:** (_____)_____

Please **INITIAL** each item below you wish to have released and/or discussed**:**

_____ ***Appointment Days and Times**
_____ Scheduling an Appointment
_____ Billing
____ Court/Probation Records
_____ ***Treatment Summary**
_____ Psychological Evaluation Report
_____ IEP's, Special Education Records
____ Work Records, HR reports
____ ***Verbal Communication with Provider regarding treatment**
____ Other (specify) _____

**each of these items need to be checked for any hospital day program/discharge*

I understand that upon written request, I have the right to revoke this consent at any time.

In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information.

_____ _____ _____
Signature of Adult Client or Legal Guardian | Print Name | Date

_____ _____ (___)_____
Address | City, State, Zip | Phone#

If you are the legal guardian signing on behalf of the child client please see below:

Client is _____ years of age. Any client 12 years and above must sign and date below:

_____ _____ _____
Signature | Print Name | Date

_____ _____ _____
Witness Signature | Print Name | Date

Fax on: _____ to: _____

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