BRAIN HEALTH CLINIC

Request/Authorization to Release Confidential Records and Information

I hereby authorize: _____

Person or facility: _____

Address: _____

Phone: _____

to release information from records about _____for the following purpose(s): further mental health evaluation, treatment, or treatment planning. These records concern the time between _____and_____.

The information to be disclosed is below:

- Intake and discharge summaries
- Medical history and evaluation(s)
- Mental health evaluations
- Developmental and/or social history
- Educational records (if applicable)
- Progress notes, and treatment or closing summary

HIV-related information and drug and alcohol information contained in these records will be released under this consent.

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 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 within 90 days, except to the extent that action based on this consent has already been taken. **This consent will expire automatically after 12 months from the date on which it is signed, or upon fulfillment of the purposes stated above.**

Signature of client: _____ Printed name: _____ Date: _____

Signature Parent/guardian: _____ Date: _____

Printed name: _____ Relationship: _____

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

Signature of witness: _____ Printed name: _____ Date: _____

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This is a strictly confidential patient medical record. Redisclosure or transfer is expressly prohibited by law.

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