Authorization for Release and Acquisition of Confidential Information

I authorize ACCESS LIVING to acquire and/or release the following information concerning:

Client:______________________________ Date of Birth: ________________

Address:____

City:_________________ State:_________ Zip Code:_____________

☐ Mental Health Records

☐ Medical Records

☐ Law Enforcement records

☐ School Records

☐ Behavioral record

☐ Psychotherapy Notes (this release cannot be used to release additional information

I authorize use of this information as it pertains to the assessment, diagnosis and treatment of a psychiatric or behavioral condition through services offered by ACCESS LIVING. This includes the following source or contact deemed necessary by the ACCESS LIVING representative that will increase the quality of services. I acknowledge that information passed with this disclosure may not be further protected by federal law and could be used or redirected by the receiving party. I understand that signing this release is voluntary and do not need to sign it to ensure service or care.

This information may be ☐ acquired and/or ☐ released to/from the following:

Organization:_______________________________ Contact:____________________________

Address:____

City:_________________ State:_________ Zip Code:_____________

Phone:________________________Fax:________________________

This release is effective until the following conditions are met or until right to release information is revoked by the authorized signer:

☐ Requested information is exchanged

☐ One year from signature date

☐ Until (date)_______________

I acknowledge that I have the legal authority to authorize disclosure of protected health information about:

☐ Myself

☐ My Child

☐ My Ward Describe:____

_________________________________ ____ ____________

Client/Parent/Guardian (Print Name) Client /Parent/Guardian Signature Date

_______________________________________ __________________________

Minor signature if 14 years or Older Date