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**INFORMED CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION**

Date of request: ____________________________

Re: _______________________________________ D.O.B.: ______________________
(name of client)

Address: ______________________
______________________

I, the undersigned, hereby authorize ______________________

to release to ________________________________________________________________
________________________________________________________________
________________________________________________________________
(name and address of person/organization to receive information)

any pertinent information he/she may have regarding my (self/child)for the purpose of continuing medical/psychiatric care. The information may be disclosed in the following manner (indicate yes / no)

________ ORAL ________ WRITTEN _______ FAXED

I understand that my records are protected by federal law (42 CFR part 2) and cannot be disclosed without this written consent unless otherwise provided in the federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it (i.e., information already disclosed) and that in any event this consent expires automatically as described below. My signature also means that I have read this form and/or have had it read to me and explained in a language that I can understand. I further release _____________________ from any and all legal responsibility and liability that may arise from the act I have hereby authorized.

Specific date, event, or condition upon which this consent expires unless previously revoked by me: upon termination of treatment.

Executed on this _____________________ day of ________________________20_____.

__________________________ (Signature of Witness)

____________________________ (Signature of Patient)

____________________________ (Signature of Parent/Guardian)