



CLIENT NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY/ZIP: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_

DATE: \_\_\_\_\_

**AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize \_\_\_\_\_

(Agency/Address)

to release/exchange the following written/verbal information with \_\_\_\_\_

(Agency/Address)

For the purpose of \_\_\_\_\_

The following information may be shared (check all items):

- Mental health assessment and treatment      \_\_\_ Yes \_\_\_ No \_\_\_ N/A
- Psychiatric evaluation and treatment            \_\_\_ Yes \_\_\_ No \_\_\_ N/A
- Substance abuse assessment and treatment      \_\_\_ Yes \_\_\_ No \_\_\_ N/A
- HIV/AIDS status                                        \_\_\_ Yes \_\_\_ No \_\_\_ N/A
- Summary of treatment                                \_\_\_ Yes \_\_\_ No \_\_\_ N/A
- Discharge summary                                    \_\_\_ Yes \_\_\_ No \_\_\_ N/A

This consent is valid until \_\_\_\_\_  
(If no date is listed, release is valid for 1 year)

\_\_\_\_\_  
Clinician Signature

I understand I may revoke this consent at any time\* and I have the right to inspect and copy the information to be released. It has been explained to me that if I refuse to sign this Release of Information, the following are the consequences (specify, if any):

\_\_\_\_\_

\*Any revocation of consent shall have no effect on any disclosures made prior thereto.

I understand the information obtained as a result of this release may not be redisclosed unless I specifically consent to it. Catholic Charities will not redisclose any information from outside sources without a specific signed release of information.

Client Signature \_\_\_\_\_

Date \_\_\_\_\_

Guardian/Parent/Legal Relationship \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

Signatures of all clients between the ages of 12 to 18 and parent/guardian are required for disclosure information.