**AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION**

Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous Names: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INFORMATION IS TO BE DISCLOSED TO AND/OR RECEIVED FROM:

Name of Person and/or Agency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PURPOSE OF RELEASE:

\_\_\_\_\_\_\_ Evaluation \_\_\_\_\_\_\_ Treatment \_\_\_\_\_\_\_\_ Transfer of Services \_\_\_\_\_\_\_\_\_\_ Other

I AUTHORIZE EMILY SHOEMAKER TO RELEASE/REQUEST THE FOLLOW INFORMATION:

\_\_\_\_ ALL MENTAL HEALTH RECORDS

\_\_\_\_ INTAKE ASSESSMENT

\_\_\_\_ PSYCHOTHERAPY NOTES

\_\_\_\_ TREATMENT PLAN

\_\_\_\_ INFORMATION RELATED TO SUBSTANCE ABUSE/CHEMICAL DEPENDENCY

\_\_\_\_ INFORMATION RELATED TO HIV/AIDS AND OR SEXUAL TRANSMITTED DISEASES

\_\_\_\_ OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I may revoke this Authorization at any time except to the extent that action has been taken in reliance to the initial request, and that in any event this Authorization expires 90 days after last dated signature.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Client Signature Date

***Parent/Legal Guardian signature is required for all children under age 13.*** For Children age 13 and over, we encourage the Parent/Legal Guardian to sign but it is not required. I understand that the information being requested for the above named Minor Child may include information regarding myself, the Parent/Legal Guardian, relevant to my child’s condition and treatment. I consent to the disclosure of such information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness signature Date