PRO BONO COUNSELING

Your Mental Health Connection

Authorization to Release Confidential Records and Information

(the "Records Authorization")

1. RELEASOR INFORMATION.

Name _____ Phone # _____

Street Address _____

City, State and Zip Code _____

Email Address _____

2. RELEASEE AUTHORIZATION.

a. I hereby authorize a release of information to the following person or company:

Name of Organization _____ Name of Contact Person _____

Street Address _____

City, State and Zip Code _____

Phone # _____ Email Address _____

b. I authorize a release of confidential information as follows: (*Check one)*

☐ Release AND receive information from _____;

☐ To ONLY receive information from _____;

3. PURPOSE FOR DISCLOSURE.

The purpose for the disclosure is: (*Check one)*

☐ Further mental health evaluation, treatment, or care.

☐ Other Purpose: _____

Date of Treatment/Services: _____

4. INFORMATION TO BE DISCLOSED.

The following information may be disclosed: (*Check all that apply)*

☐ Intake/Discharge Summary	☐ Medical History/Assessments
☐ Treatment Plans	☐ Psychological Reports
☐ Social History	☐ Legal Information
☐ Educational Records	☐ Progress/Treatment notes
☐ Diagnostic Results	☐ Court ordered Evaluations
☐ Other (*please specify)*: _____	

Please Note: *HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here:*

☐ Do not release HIV-related information.

☐ Do not release drug and alcohol information.

5. EXPIRATION.

This Authorization will: (*Check one)*

☐ Will expire automatically after discharge, upon fulfillment of the purposes stated above,

☐ This Authorization will expire on: _____.
Date Here

By signing below, I acknowledge that this request for a release of my protected confidential health information is entirely voluntary on my part. I understand that I may take back this consent at any time except for instances when action based on this consent has already been taken (such as a release or records).

I fully understand this the implications of this Authorization, the nature of the records held in my name, their contents, and the likely consequences and implications if they were to be released, and understanding and knowing this, I sign as follows:

_____ _____
Signature Date

If client is a minor under the age of 16, a parent/guardian must also sign:

_____
Name of Parent/Guardian

_____
Relationship to Minor

_____ _____
Signature Date