THE CLINIC
FOR MENTAL HEALTH & WELLNESS

AUTHORIZATION TO RELEASE / OBTAIN MEDICAL, PSYCHIATRIC, ALCOHOL, SUBSTANCE USE RECORDS, HIV RELATED INFORMATION

PATIENT INFORMATION

LAST NAME:	FIRST NAME:	MI:	NICKNAME:
DATE OF BIRTH:	SOCIAL SECURITY NUMBER::		
HOME ADDRESS:	CITY:	STATE:	ZIP:
PHONE NUMBER:	EMAIL:		

***I HEREBY AUTHORIZE AND REQUEST THE CLINIC FOR MENTAL HEALTH AND WELLNESS MAY RELEASE/REQUEST THE FOLLOWING:**

(_____) **ALL INFORMATION**	
(_____) SUBSTANCE ABUSE EVALUATION	(_____) MEDICATION TREATMENT NOTES
(_____) CLINIC VISIT NOTES / PSYCHOTHERAPY NOTES	(_____) PSYCHIATRIC EVALUATION
(_____) NEUROPSYCHOLOGICAL / PSYCHOLOGICAL EVALUATION	(_____) INPATIENT TREATMENT RECORDS
(_____) OUTPATIENT TREATMENT RECORDS	(_____) TREATMENT PLAN
(_____) DISCHARGE SUMMARY	(_____) ACADEMIC OR EDUCATIONAL RECORDS
(_____) CLINICAL LABS, SLEEP STUDY, MEDICAL INFORMATION	(_____) OTHER

*** TO THE FOLLOWING PERSON/AGENCY***

NAME / FACILITY:			
ADDRESS:	CITY:	STATE:	ZIP:
PHONE NUMBER:	FAX NUMBER:		
EMAIL:			

INFORMATION MAY BE: (PLEASE INITIAL)

(_____) **RELEASED TO** THE CLINIC FOR MENTAL HEALTH & WELLNESS	(_____) **OBTAINED FROM** THE CLINIC FOR MENTAL HEALTH & WELLNESS

(I AM AWARE THAT THESE DOCUMENTS WILL CONTAIN VERY DETAILED, SENSITIVE INFORMATION ABOUT MYSELF OR THAT OF MY CHILD, INCLUDING FAMILY HISTORY; LEGAL HISTORY; SOCIAL HISTORY; MEDICAL HISTORY; AND TREATMENT HISTORY)

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time except in the event that the action has already been taken. Subsequent disclosure of my medical records by those receiving the authorized information is prohibited. I hereby release both parties from any liability for furnishing the information released or requested. I have read the above and acknowledge that I understand the terms and conditions of this authorization. Without my expressed **written** revocation, this consent will **EXPIRE** ***on this date: _____ OR in ONE (1) YEAR from the date signed.***

PATIENT'S PRINTED NAME

PATIENT'S SIGNATURE OR **AUTHORIZED PERSON'S NAME / SIGNATURE** IN LIEU OF PATIENT **DATE**