

AUTHORIZATION FOR RELEASE OF INFORMATION

This form is a signed authorization and request for the release of information about:

First, Middle & Last Name

Date of Birth

Current Home Address

City, State & Zip Code

Information is requested from:

Name of Agency or Person Releasing (providing) information

The requested information is to be sent to:

Name of Agency or Person Obtaining Information

Mailing Address

City, State & Zip Code

The following, specific information is to be released:

- Medical or medically-related history, examination, laboratory tests, evaluations, & treatment reports.
- Psychological test/evaluation reports.
- Psychiatric evaluation reports
- Social history information including family, education, employment and other related information
- Summary of previous services, treatment or findings.
- Periodic progress reports of current treatment or services rendered
- Other information specified as follows: _____

This information is to be used for the following purposes:

- To develop an effective and coordinated plan of services, treatment or rehabilitation
- To coordinate medical, psychological, psychiatric, behavioral or other personal support services
- To coordinate judicial or legal proceedings.
- Other reason specified as follows: _____

This information may not be re-disclosed by either party to any other individual or agency without the written consent of the above named person. This consent for the release of information may be revoked in writing at anytime by the undersigned, and is automatically null and void one year from the date of the signature(s) below.

Signature of person about whom information is being requested Date

Signature of Parent/Legal Guardian/Conservator Date

Signature of Witness Date