**AUTHORIZATION TO RELEASE INFORMATION**

I authorize MULTICULTURAL COUNSELING & CONSULTING CENTER to release to, and receive from

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

(Name)

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

(Address)

[ ] School System [ ] Hospital [ ] Private Clinician

[ ] Pediatrician [ ] Court System [ ] Other

[ ] Family Member/Support person

the following information on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Patient Name) (DOB)

\_\_\_\_\_ Medical Records \_\_\_\_\_ Academic Records/Educational Evaluation

\_\_\_\_\_ Medical History/Physical \_\_\_\_\_ Treatment Plan/Patient Progress

\_\_\_\_\_ Psychological Evaluation \_\_\_\_\_ Discharge Summary

\_\_\_\_\_ Social History \_\_\_\_\_ Special Education File

\_\_\_\_\_ Neurological Evaluation \_\_\_\_\_ Immunization Records

\_\_\_\_\_ Results of Drug and Alcohol \_\_\_\_\_ Other (Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment/Testing

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

Approximate dates of service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have been informed of the type of information being released, the benefits and disadvantages ( if any ),

and understand that treatment services are not contingent upon my decision concerning the signing of this release. I have also been informed that my photocopied signature is as valid as the original.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

(If patient is a minor)

Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

Note: Remember to ask for permission to release information to any key person who has worked with the

patient and family ( i.e. probation officer, hospital clinician, private practice clinician, teacher, guidance

counselor, attorney, etc. )

As required by Section 2.32(a) PROHIBITION ON DISCLOSURE –rule: “This information has been

disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations

( 42 CFR Part 2 ) prohibits you from making any further disclosure of it without the specific written

consent of the person to whom it pertains or otherwise permitted by such regulations. A general

authorization for the release of medical or other information is NOT sufficient for this purpose.”