Authorization to Release/Obtain Information to Family Members

Client: _____ Date of Birth_____

I hereby authorize _____ to discuss my therapeutic plans/interactions with:
(Therapist)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

This consent may be revoked by me at any time. This content, unless revoked earlier, shall be valid throughout my treatment and for 90 days after discharge.

In accordance with the specification listed above, I authorize the disclosure or exchange of my records pertaining to mental health records, drug and alcohol treatment, AIDS or AIDS related illness, and/or HIV test results.

I hereby consent and authorize the release of information as described on this form. I have given this consent voluntarily, and I understand that authorizing *this disclosure is not required in order to receive service and treatment*. The recipient of the records may re-disclose the information that I authorize to be released only if allowed by law. I also know that I may inspect and receive a copy of released information (upon payment of the usual fee) and receive a copy of this consent form.

_____ _____
Signature of Patient / Personal Representative Date