Request / Authorization to Release Confidential Records and Information

Kimberly Keiser and Associates

I hereby authorize: _____ to release information from records

to _____ for _____, born on ____ / ____ / _____,

and whose Social Security number is _____ –_____ – _____ , for the following purpose(s):

☐ Further mental health evaluation, treatment, or care ☐ Rehabilitation program development or services

☐ Treatment planning ☐ Research ☐ Other: _____

These records concern the time between _____ and _____.

In the boxes below, the information to be disclosed is marked by an x; the items not to be released have a line drawn through them; page numbers are indicated when appropriate; and written dates indicate when those records were mailed to the requester.

☐ Intake and discharge summaries _____ ☐ Medical history and evaluation(s) _____

☐ Mental health evaluations _____ ☐ Developmental and/or social history _____

☐ Educational records _____ ☐ Progress notes, and treatment or closing summary _____

☐ Other: _____

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.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above. I understand that if the person or organization that receives this information is not a health care provider or health insurer the information may no longer be protected by federal privacy regulations.

_____	_____	_____
SIGNATURE OF CLIENT	PRINTED NAME	DATE

_____	_____	_____	_____
SIGNATURE OF PARENT/ GUARDIAN / REPRESENTATIVE	PRINTED NAME	RELATIONSHIP	DATE

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____	_____	_____
SIGNATURE OF WITNESS	PRINTED NAME	DATE

☐ Copy for patient or parent/guardian ☐ Copy for source of records ☐ Copy for recipient of records