AUTHORIZATION TO OBTAIN OR RELEASE CONFIDENTIAL INFORMATION

I hereby authorize Family Connections, LLC to:

___x__ Obtain from: **______ Release to:**

____

Agency/ Provider **Street** **City** **Zip** **Phone**

_____ Obtain from: **____x__ Release to:**

____

Agency/ Provider **Street** **City** **Zip** **Phone**

Client Name: ____ **DOB:** ______________________

_____ **Mental health information including psychosocial history/assessments, psych testing, psychiatric and psychological evaluations, treatment plans, discharge summaries.**

______ **Education information, including Permanent Record Card, academic evaluations, psych and educational testing, educational recommendations and vocational assessments. MDT reports and IEP's.**

_____ **Medical information including but not limited to physical exams, health history, immunization records, lab results, medication history.**

_____ **Other information pertinent to treatment planning:** ____________________________________

- **The information shall be obtained and / or released via: _x_verbal exchange _x_ mail _x_confidential fax _x_in person**
- **To cover the following time periods: from __________ to __________ or date of discharge.**
- **The information shall be used for the purpose of _x_evaluation and assessment, _x_treatment planning, _x_coordination and consultation with other treatment providers.**

I understand that the information obtained/released under this authorization is protected by laws regarding confidentiality of the State of Rhode Island. I further understand that this authorization will automatically expire one year from the date of signing and that it may be withdrawn by written request at any time. I release Family Connections, LLC from any liability that may arise in connection with obtaining and/or releasing this information, provided that said release of information is done substantially in accordance with applicable law. A photocopy of this authorization is as valid as the original.

I have read and understand the purpose of this release and am signing this authorization voluntarily. I understand that I may revoke my consent at any time except to the extent that action has been taken in reliance upon it.

____

Printed name of client **Signature of client** **Date**

____

Printed name of parent / guardian **Signature of parent / guardian** **Date**

____

Becky Carter, LMHC **Signature of witness** **Date**

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