CONSENT FOR RELEASE OF INFORMATION

I hereby authorize _____to release/receive specified information from the record of: _____ to _____.
This information shall include (nature and extent of information to be released):

_____

_____

_____ .

I understand this information will be used for: _____

_____

_____ .

Other information: _____.

I understand the contents to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this consent is truly voluntary and is valid for 180 days. I understand that I may revoke this consent at any time except to the extent that information has already been released before I revoke it.

_____	_____
Client Signature	**Client Representative Signature**
_____	_____
Printed Name	**Printed Name and relationship**
_____	_____
Date	**Staff Name**

*Not to be used for Protected Health Information (PHI)