**Aurora Family Counseling**

**Request/Authorization to Release Confidential Records and Information**

I hereby authorize (person or facility):_____
_____
Address: _____
_____Phone:_____
To (mark one) ◯ release ◯receive ◯release and receive information from records about _____, born on_____, for the following purpose(s):

◯Further mental health evaluation, treatment, or care ◯Treatment planning

◯Legal purposes ◯Other:_____

The information to be disclosed is marked below, items not to be released have been marked out and initialed. Authorized disclosure is ◯Written only ◯Verbal only ◯Written and Verbal.

◯Intake and discharge summaries____ ◯Medical history and evaluations___

◯Mental health evaluations___ ◯Developmental and/or social history___

◯Educational records___ ◯Progress notes___

◯Treatment and/or discharge 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 on _____(date) or one year from the date it was signed, whichever is sooner, or upon fulfillment of the purposes stated above.

_____ _____ _____
Signature of client Printed name Date

_____ _____ _____
Signature of parent/guardian/ representative Relationship Date