

**Authorization for Release of Confidential Information**

I understand that the information released may be subject to release by the person(s)/agency receiving it and no longer protected by the federal privacy regulations. I also understand that I may **revoke** this authorization/consent by notifying Inside Out Life Development, in writing, of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any affect on actions taken by Inside Out Life Development in reliance on it before I revoked it. I understand that I may **refuse** to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. A photocopy of this authorization will be treated in the same manner as the original. I understand this authorization/consent will expire in **one year**.

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_ Zip \_\_\_\_\_

I authorize Inside Out Life Development, Inc. to \_\_\_\_\_ receive information from and/or \_\_\_\_\_ release information to:

Agency/Individual: \_\_\_\_\_

Address: \_\_\_\_\_ Zip \_\_\_\_\_

Phone: \_\_\_\_\_ FAX: \_\_\_\_\_

Information to be released/exchanged \_\_\_\_\_ verbally and/or in \_\_\_\_\_ writing (Check boxes that apply):

- Name                       Address                       Phone Number                       Date of Birth
- All Records and Ongoing Communication
- Diagnostic Report                       Treatment Plan                       Progress Report                       Family / Social History
- Testing Results                       Medical History                       Social Services Case Records                       School Records
- Psychological Evaluation                       Psychiatric Evaluation                       Discharge Summary                       Other \_\_\_\_\_

**ALL RECORDS PERTAINING TO MENTAL HEALTH, ALCOHOL AND/OR DRUG ABUSE, AND/OR AIDS/AIDS RELATED ILLNESES WILL BE RELEASED UNLESS OTHERWISE INDICATED IN WRITING HERE:**

- This release is required for the purpose of: (Check boxes that apply):
- Coordination of services                       Determination of eligibility for services                       Social Service involvement
  - Continued / follow-up care                       Court / Legal action                       Other \_\_\_\_\_

**This form must be fully completed before signing.**

\_\_\_\_\_  
Signature of Client                      Date

\_\_\_\_\_  
Signature of Parent, Legal Guardian                      Date

\_\_\_\_\_  
Signature of Witness                      Date