

**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 InsideOut 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 InsideOut 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; Michelle Hunt-Graham MA, LMFT. 612-750-0011 fax 201-221-8287  
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):**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Name  | <input type="checkbox"/> Address                | <input type="checkbox"/> Phone Number                 | <input type="checkbox"/> Date of Birth           |
| <input type="checkbox"/> <b><u>All Records and Ongoing Communication</u></b> |   |   |  |
| <input type="checkbox"/> Diagnostic Report                                   | <input type="checkbox"/> Treatment Plan         | <input type="checkbox"/> Progress Report              | <input type="checkbox"/> Family / Social History |
| <input type="checkbox"/> Testing Results                                     | <input type="checkbox"/> Medical History        | <input type="checkbox"/> Social Services Case Records | <input type="checkbox"/> School Records          |
| <input type="checkbox"/> Psychological Evaluation                            | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Discharge Summary            | <input type="checkbox"/> 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):**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Coordination of services   | <input type="checkbox"/> Determination of eligibility for services | <input type="checkbox"/> Social Service involvement |
| <input type="checkbox"/> Continued / follow-up care | <input type="checkbox"/> Court / Legal action                      | <input type="checkbox"/> Other _____                |

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

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

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

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