

THE COUNSELING COTTAGE
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AUTHORIZATION FOR RELEASE/OBTAINING INFORMATION

I, _____, _____
 Name date of birth Social Security Number

Authorize _____ To Disclose to _____

The following information from my records:

- | | |
|---|------------------------------|
| _____ Initial Assessment/social history | _____ Medication Prescribed |
| _____ Psychiatric/medical history | _____ Vocational |
| _____ Psychological | _____ School Records |
| _____ Educational | _____ Other Specified: _____ |

 THIS AUTHORIZATION EXPIRES 1 YEAR FROM THE DATE SIGNED UNLESS OTHERWISE NOTED. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION IN WRITING AT ANY TIME. I FURTHER WAIVE AND RELEASE PAMELA SMITH MCSPADDEN FROM LIABILITY RESULTING IN THE RELEASE/OBTAINING OF THE ABOVE INFORMATION.

 Signature of Client/Guardian Date

 Signature of Witness Date

 Notice to Recipients of Information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42,CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client /patient.

Date Released _____ Released by _____