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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
_____Psychiatric/medical history
_____Psycological
_____Educational
_____ Medication Prescribed
_____Vocational
_____School Records
_____Other Specified:_____

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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

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Notice to Recipients of Information: This information has been disclosed to you from records whose condientiality 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 ay use of the information to criminally investigate or prosecute any alcohol or drug abuse client /patient.

Date Released_____ Released by_____