

*Authorization to Release Information*

To facilitate informed services, I \_\_\_\_\_ (DOB: \_\_\_\_\_ )  
hereby authorize the mutual release/exchange of information concerning:

- |  |                             |
|--|-----------------------------|
| _____ Information Regarding Previous Treatment | _____ Progress in Treatment |
| _____ Medical Information                      | _____ Evaluation Results    |
| _____ Mental Health Information                | _____ Other: _____          |
- 

between **Mothering Voice Psychological Services** and

Person: \_\_\_\_\_

Organization: \_\_\_\_\_

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

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I understand that records containing information about the diagnosis, treatment, or referral of alcohol and drug abuse problems are protected under federal confidentiality regulations (42 CFR, Part 2 – Alcohol and Drug) and cannot be disclosed without my written consent. I also consent to the release of that information. \_\_\_\_\_ (client initial)

I understand that my records may contain information regarding testing, diagnosis, or treatment of HIV/AIDS, or sexually transmitted diseases. I consent to the release of that information. \_\_\_\_\_ (client initial)

Other parties receiving this information are prohibited from re-disclosing these records, unless expressly permitted by my written consent, unless disclosure is otherwise permitted by federal regulations.

**This consent will expire upon the completion of treatment or any other agreed upon date.**

Client signature: \_\_\_\_\_ Date: \_\_\_\_\_