

**CHILD AND FAMILY SERVICES, INC.
RELEASE/REQUEST AUTHORIZATION FORM**

CLIENT NAME _____ CLIENT # _____ D.O.B. _____

I HEREBY AUTHORIZE CHILD AND FAMILY SERVICES, INC. TO:

<input type="checkbox"/> RELEASE TO: (C&F to <u>send</u> the following information from the record of the above named client) <input type="checkbox"/> Verbal information <input type="checkbox"/> Psychiatric evaluation & treatment course <input type="checkbox"/> Case History <input type="checkbox"/> Psychological (Testing and Results) <input type="checkbox"/> Assessments including Diagnosis <input type="checkbox"/> Treatment Plan(s) / Treatment Updates <input type="checkbox"/> Hospital Admission & Discharge Summaries <input type="checkbox"/> Other <input type="checkbox"/> All health information about me as described in the preceding checkboxes excluding: _____	<input type="checkbox"/> REQUEST FROM: (C&F to <u>receive</u> the following information from the record of the above named client) <input type="checkbox"/> Verbal information <input type="checkbox"/> Psychiatric evaluation & treatment course <input type="checkbox"/> Case History <input type="checkbox"/> Psychological (Testing and Results) <input type="checkbox"/> Assessments/Diagnosis <input type="checkbox"/> Treatment Plan(s)/ Treatment Updates <input type="checkbox"/> Hospital Admission & Discharge Summaries <input type="checkbox"/> Education <input type="checkbox"/> Medical/Exam & lab results <input type="checkbox"/> Social Service <input type="checkbox"/> Other _____ <input type="checkbox"/> All health information about me as described in the preceding checkboxes excluding: _____ Please send to the attention of: _____ at Child and Family Services, Inc., 800 Purchase St., New Bedford, MA 02740 1 st Request Sent: _____ 2 nd Request Sent: _____
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Name _____
 Address _____
 City/State/Zip _____

This information is needed for the purpose of ongoing treatment planning and coordination of care.

I understand that my record may contain information about infectious diseases including my HIV (AIDS) status, alcohol and/or drug abuse, venereal disease, information relative to the diagnosis or treatment of my mental or emotional conditions. All is to be shared with the same party. I understand that the agency abides by Federal Confidentiality Regulations (42CFR Part 2) published July 1, 1975 which protects the confidentiality of my record and that information contained in my record cannot be disclosed without consent unless otherwise provided for in the regulations.

If I am a parent or guardian signing this Authorization, I represent that I have legal custody of the client, that there is no pending court action involving visitation and/or custody issues or other type of court action for which this information is sought. If I have legal custody of the client by means of a Court Order, an original of such Order is attached hereto. If there is any such pending court action, I have attached hereto a written description of such action including the name and docket number of the case.

I understand that this directive is subject to revocation at any time upon written request. Otherwise this consent will expire upon termination of services from Child & Family Services.

I herewith release and hold harmless the Child and Family Services, and any of its officers, agents, employees, directors or volunteers, from any liability for the release of any information provided in accordance with this directive.

Check here if client refuses contact with the above named person/program and have client sign below. This does not affect client's ability to receive treatment.

Signed Under the pains and penalties of perjury:

 Date Signed Parent/Guardian with Legal Authorization (where applicable)

 Client's Signature Witness

REVOCATION OF RELEASE FOR INFORMATION	
(ONLY TO BE SIGNED WHEN REVOKING RELEASE)	
_____ Date Signed one)	_____ Parent/Guardian Signature Where Applicable (Please circle)
_____ Client's Signature	_____ Witness