

Authorization for Release of Information – Minor Child

Name of Treatment Facility

RE: _____ Birthdate: _____

Address: _____

This will authorize _____
Name and Address

To release to _____
Name of Person / Organization and Address

Information from the clinical record maintained while I and / or persons under my guardian was / are a client at the above facility during _____
Date

Designate which of the following is to be released:

Summary of Social / Family History Summary of Medical History Psychological Testing
 Summary of Psychiatric History Discharge Summary Specify

For the purpose of _____

I acknowledge that information to be released may include material concerning drug and alcohol and mental health treatment, which is protected by federal law. My signature below authorizes release of all the above noted information to _____, counsellor. **I understand that all information received will be treated as confidential.**

I understand that I may revoke this consent at any time and that upon fulfillment of the above stated purpose(s), this consent will automatically expire without any express revocation.

Client or Guardian Signature

Relation to Client

Date

Counsellor's Signature

Date