

AUTHORIZATION OF RELEASE OF RECORDS OR INFORMATION

I (we) the undersigned authorize and request *Jenifer Arsenault, LCSW* to release/obtain confidential professional information, including personal, psychological and psychiatric records and opinions, and privileged communications, from the record of:

_____ / ____ / ____
(Patient Name) **(DOB)**

___ **Disclose MY ENTIRE RECORD** AND/OR ___ **Obtain MY ENTIRE RECORD**

from:

(Name of agency, attorney, school counselor, therapist, etc.)

(Address, city, state and zip code)

Phone: () _____ **Fax:** () _____

_____ **MY ENTIRE RECORD**

_____ **CONTINUATION OF CARE**

_____ **COORDINATION OF CARE**

I understand that the records to be released may contain information pertaining to psychiatric, drug and/or alcohol abuse treatment, and may also contain confidential HIV (AIDS) related information.

FORM IN WHICH INFORMATION SHOULD BE RELEASED: ___ **VERBAL** ___ **COPY**
___ **WRITTEN**

I MAY REVOKE THIS CONSENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE UPON IT. If I do not revoke it, this consent will expire one (1) year after I have terminated treatment with all providers.

Signature of patient

Signature of parent, guardian or authorized representative

Date

Witness

I understand that further disclosure of the information to be disclosed may not be made without my written consent or as otherwise restricted by Federal Regulations (42 Code of Federal Regulations, Part 2, confidentiality of Alcohol and Drug Abuse Treatment Patient Records).