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