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OFFICIAL RELEASE OF CONFIDENTIAL INFORMATION

Client Name: ____ Date of Birth: ____________
Client Name: ____ Date of Birth: ____________
Client Name: ____ Date of Birth: ____________
Client Name: ____ Date of Birth: ____________

I hereby authorize Dr. Kevin Albert to obtain/release information to/from:

Agency/Individual: ____
Relationship to Client: ____
Email Address: ____
Phone Number: ____________________________ Fax Number: _______________________

To specific materials requested or to be released are listed below:

_______ Medical
_______ Laboratory Data
_______ Progress Reports
_______ Summary of Treatment
_______ Information related to Parental Responsibilities Evaluation
_______ Dates of Treatment Only
_______ Psychological Test Records
_______ Diagnosis
_______ Educational/School Records

The purpose of the requested release of information is for the purpose of:

_______ Treatment or Evaluation
_______ Parental Responsibilities Evaluation

I understand that the information to be released may include material that is protected by state and/or Federal Regulations 42 C.F.F., Part 2, applicable to either mental health or drug/alcohol abuse or both. My signature authorizes release of all such information as specified above. I understand that this release expires on ___________________, or when treatment/evaluation work is completed, if prior to the expiration date. I also understand that I have the right to revoke this release, in writing, except to the extent the Practitioner has already made use of this release.

Dr. Kevin Albert is not responsible for any information forwarded to other parties once it is released. Re-disclosure by the recipient may no longer be protected by the HIPPA Privacy Regulation.

____
Date

____
Signature of Client

____
Witness

____
Signature of Parent/Guardian

____
Print Name(s)