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Request/Authorisation to Release Confidential Records and Information

I hereby authorise:

Person or facility: _____

to release information from records about _____, born on _____,
for the following purpose(s):

- Further mental health evaluation, treatment, or care Rehabilitation program development or services
 Treatment planning Research Other: _____

In the boxes below, the information to be disclosed is marked by an X, the items not to be released have a line drawn through them and, page numbers are indicated when appropriate. Written dates indicate when those records were mailed to the requester.

- Intake and discharge summaries _____ Medical history and evaluation(s) _____
 Mental health evaluations _____ Developmental and/or social history _____
 Educational records _____ Progress notes, and treatment or closing summary _____
 Other: _____

I have had explained to me and fully understand this request/authorisation to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time except to the extent that action based on this consent has already been taken.

Signature of patient

Printed name

Date

Signature of parent/guardian/representative

Printed name

Relationship

Date

I witnessed that the person understood the nature of this request/authorisation and freely gave his or her consent, but was physically unable to provide a signature.

Signature of witness

Printed name

Date