



AUTHORIZATION TO DISCLOSE AND RELEASE INFORMATION

Client Name First Name Middle Initial Date of Birth

Address

Phone Number

I, (parent/guardian) _____, hereby authorize Potomac Pathways to release, disclose, and receive clinical, therapeutic, and/or educational records for the following purpose(s):

- Authorization to release and receive information regarding counseling and therapy care and treatment.
- Authorization to release and receive information held under the Drug Office and Treatment Act of 1972 (PL-92255) and the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act Amendments of 1974. I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.
- Authorization to release and receive information related to Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).
- Authorization to release and receive information regarding academic history, educational, and behavioral issues, and school records.

Release to / Receive from:

Name of Provider/Person

Address

Phone

Specific information to be released and/or received (**check and initial to approve**):

- Assessments and evaluations (specify): Psychosocial history Discharge summary
- Entire mental health record Summary of treatment
- Correspondence (specify): _____
- Other (specify): _____

Purpose(s) for which information is to be released and/or received (**check and initial to approve**):

- continuity of care referral consultation personal
- other (please describe)

I do not authorize the release of the following information(specify): _____

Revocation/Expiration: I understand that I may revoke this authorization in writing at any time, except for actions that have already been taken prior to this request. (Forms are available from the therapist.) **This authorization will expire one year after the signature below unless otherwise specified.** This agency is hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated

Client signature Date

Parent / Guardian signature Date