FamilyMeans
Authorization for Release of Confidential Information

PLEASE RETURN INFORMATION TO THE ATTENTION OF STILLWATER OFFICE (School-Based Mental Health)

I, _____ authorize FamilyMeans to:

- ☐ Disclose information to:
- ☐ obtain information from:
- ☐ Exchange information with:
- ☐ notify physician:

_____

(Name of Person) **(Name of Agency)**

_____

(Address)

_____ _____ _____

(City) **(State)** **(Zip)**

_____ _____

Fax # **Phone #**

Regarding: _____ _____

(Name) **(Date of Birth)**

_____

(Address)

☐ Myself ☐ my daughter/son ☐ other: _____

The information to be disclosed is:

- ☐ Discharge/treatment summary
- ☐ Admission/Intake Summary
- ☐ Progress notes
- ☐ Diagnostic Impressions
- ☐ Academic records/school functioning
- ☐ Chemical Dependency Evaluation
- ☐ Psychological testing
- ☐ Medical history & physical exam
- ☐ Social/Court Services Summary
- ☐ Medication history
- ☐ Other: _____

The purpose of this disclosure is: _____

I understand that my records are protected by the Data Privacy regulations and cannot be disclosed without written consent unless otherwise provided for in the regulations, and that I may revoke the consent at any time. I understand that this consent will automatically expire without my express revocation upon fulfillment of the above stated purpose or one year from this date, whichever is sooner. I have the right to receive a copy or review information to be disclosed, if requested.

_____

Signature of client or (if minor) parent/guardian **Date**

Sent: _____ Time: _____ Initials: _____ Fax #: _____

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