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AUTHORIZATION FOR RELEASE AND EXCHANGE OF CONFIDENTIAL RECORDS AND INFORMATION

I hereby authorize Cari Foote, M.A., LPC, LMFT at the address in the letterhead at the top of this form to release and exchange confidential information regarding:

_____, DOB: _____

To: Person or Facility: _____

Address: _____

_____

Phone number: _____

Fax number: _____

The purpose of this release or exchange is:

- ☐ Further mental health evaluation, treatment, treatment plan development or care
- ☐ Treatment plan implementation and coordination
- ☐ Legal Proceedings

The information to be disclosed is marked by an x in the boxes below, and the items not to be released have a line drawn through them.

□ Intake and discharge summaries □ Mental health evaluation □Developmental and/or social history □ Educational records □ Progress notes, and treatment or closing summary
□ Other _____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: □ Do not release.

I have had explained to me and fully understand this authorization to release and exchange records and information, including the nature of the records, their contents, and the consequences an implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time and that I must do so in writing. This withdrawal of consent will not affect any action that has already been taken.

This authorization will be in effect from _____ to _____.

_____	_____	_____
Signature of client	Printed name	Date

_____	_____	_____	_____
Signature of parent/guardian	Printed Name	Relationship	Date