



## COMPREHENSIVE CONSENT FORM for Release of Information

Regarding \_\_\_\_\_

Date of Birth: \_\_\_\_\_

I/We hereby authorize Therapeutic Living for Families to \_\_\_\_\_ send to \_\_\_\_\_ receive from:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Medical Information, including immunization records and last physical

\_\_\_\_\_ Inpatient and/or outpatient psychological/psychiatric/substance abuse treatment records

\_\_\_\_\_ Academic and educational records, including achievement testing

\_\_\_\_\_ Other: \_\_\_\_\_

I authorize Therapeutic Living for Families to speak by telephone with you about the reason for referral, any relevant history, or diagnoses and to share other information to assist with the client's treatment and/or evaluation.

This authorization to release medical information is being made to aid in planning effective evaluation and treatment for this client. I understand that no services will be denied solely because I refuse to consent to this release of information, and that I am not obligated to release them. I do release them because I believe they are necessary to assist in the development of the best possible treatment plan for the client.

In consideration of this consent, I hereby release the above source of records from any and all liability arising there from. I understand that the information disclosed pursuant to the written authorization may be re-disclosed by the recipient and is no longer protected by the federal privacy regulations. I understand that I may void this authorization, except for action already taken, at any time by means of a written letter revoking the authorization, but that this revocation is not retroactive. Unless expressly revoked earlier, this consent expires upon completion of the current treatment and/or one year from current date.

Signature of Client \_\_\_\_\_ Date \_\_\_\_\_

Signature of Custodial Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_

Signature of Witness \_\_\_\_\_ Date \_\_\_\_\_