**RELEASE OF INFORMATION**

* I understand that my records may be protected under the Federal Confidentiality Regulations (42 CFR Part 2) and, if so, cannot be disclosed without my written consent unless otherwise provided for in the regulations and/or under state specific provisions.
* I understand that my records may contain information regarding my mental health, substance use or dependency, sexuality, suicidal thoughts, and may contain confidential HIV (AIDS) related information. I further understand that by signing below, I am auth**o**rizing the release or exchange of these records to the parties named below.

Client Name: DOB:

Check all that applies: Exchange with Release to Obtain from

Name: and Therapist: and/or **Emotional Change Inc.**

Relationship: `

Address: Phone Number:

Fax Number:

**I authorize the release/exchange of the following medical records and information** (check all applicable):

All Medical Records

Medical History

Psychosocial History

Assessment of Diagnosis

Progress Notes

Treatment Plan

Substance Use Assessment and Treatment

Medicine and Treatment Record

Summary of Psychological Testing

Discharge Summary

Attendance

Other; specify:

**This information is required for:**

Summary of Previous Treatment

Continuity of Care

To keep patient’s parents or significant other informed of treatment

Insurance Review (for justification of charges, quality of care, treatment progress and/or medical necessity)

I understand that the information or records listed above will not be used for any purpose other than the intended use. The re-release of this information to parties other than those named above is prohibited**.**

I understand that I may revoke this authorization at any time, unless action has already been taken on it, by giving written notice to the parties below.

This authorization automatically expires, unless otherwise prohibited by state law, on (specific date):

Signature of Patient/Legal Guardian Relationship to patient Date signed