**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