CLIENT INFORMATION RELEASE AUTHORIZATION FORM (Over 18)

Client Name: _____Client DOB: _____

I, _____, hereby authorize Livingston Family Center's
(Client's Name)
Designee to _____ exchange/ _____ release / _____ receive information contained in my client records
(Please Initial)
from the individuals or organizations listed below and only under the conditions listed below:

Name of person(s) or organization(s) to exchange/ release/ receive information:

_____

Specific type of information to be exchanged/ released/ received:

____Intake Assessment _____Progress Notes ____Treatment Plan/Goals ____Discharge Plan/Date

____Academic/Attendance Records ____ Individual Education Plan ____Behavioral Plan

____Medical Records ____Psychiatric/Psychological Evaluation(s) ____Medication Reviews

____Other:_____

The purpose and need for such exchange/release/receive:

_____

This consent is subject to revocation at any time except in those circumstances in which the program has taken certain actions on the understanding that the consent will continue unrevoked until the purpose for which the consent was given shall have been accomplished.

Without expressed revocation, this consent expires for the following specified reasons:

A. Date: _____
B. Event or Condition: Termination of Services

_____ _____
Client Signature Date

_____ _____
LFC Representative or Witness Date