Emotional Change Inc.

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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