Authorization for Release of Information

Client Name: _____

Street Address: _____

City, State, Zip: _____

Birth Date: _____ Soc. Sec. No. _____

Home Phone: _____ Alternate Phone: _____

I, _____ authorize ASAP at Wilson Place
to release information to:

Court of Conviction

_____

_____

Information to be ____mailed _____picked up. Date: _____

Type of information to be released:
Notice of enrollment, completion notice, notice of compliance, and/or notice of non-compliance

_____

Purpose of disclosure:
_____

The information may be communicated in the following manner: ☑Oral ☑Written

This authorization shall be in effect for 12 months or completion of services following the date of signature.

I understand that I may revoke this consent at any time by notifying the providing organization in writing, except to the extent that the action has already been taken in reliance on it and that in any event this consent expires automatically as described above. I also understand Alcohol and Drug client records are protected by the Federal Law (42CFR Part 2) and cannot be disclosed without this written consent unless otherwise provided in the federal regulations.

Signature of Client
Or Guardian_____ Date: _____

Relationship to client if unable to sign _____

Witness _____
I authorize the release of the indicated sensitive records also (client to initial):
Mental Health Records..... _____ (initial)
HIV or AIDS ..... _____(initial)
Chemical Dependency..... _____(initial)
DUI Records..... _____(initial)