AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

Patient name: _____ DOB: _____

I _____ authorize the Family Care Center to:

_____ release to: _____ obtain from:

_____ exchange with (provide name or agency name and telephone number):

_____

_____

_____

_____

the following information pertaining to myself/patient (check all that apply):

_____ treatment summary _____ diagnosis _____ history/intake

_____ psychological test results _____ psychiatric evaluation/medication history

_____ dates of treatment attendance _____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts

_____ other (specify) _____

I understand that, unless lined through and initialed, information to be released may include information regarding the following conditions:

*Drug Abuse *Psychiatric Conditions/Treatment

*Alcoholism or Alcohol Abuse *HIV/Auto Immune Deficiency Syndrome (AIDS)

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Signature of Witness Date

I hereby revoke this Authorization to Disclose Information.

_____ _____

Signature of Patient Date

Family Care Center
1330 Quail Lake Loop, Suite 260
Colorado Springs, CO 80906