REQUEST FOR AND AUTHORIZATION TO RELEASE RECORDS AND INFORMATION

Client Name: _____

Patient Date of Birth: _____

Patient Identification Number: _____ (SSN last 4 numbers or SPN)

I hereby authorize HTWC, Inc. or representatives to release information and gain information from the agency or person listed below:

_____
(Name of Person or Facility: Hospital, Clinic, School, Professional, etc.)

_____
(Address, Phone number)

The purpose of the release information from my records who is listed on this letterhead or to the professional or facility listed on the line just above for the purposes(s) of (initial each item to be released):

_____ Further mental health/psychological/psychiatric evaluation,
_____ Treatment or care
_____ Rehabilitation program development or Services
_____ Chaperone Training
_____ Legal
_____ Other _____

The following information from the records is to be released (initial each item to be released):

_____ Intake and Discharge Summaries _____ Yearly Evaluation(s)
_____ Psychological Assessments _____ Child Assessment
_____ Monthly Progress Reports _____ Treatment Summary
_____ Psychological testing _____ Certificate completion

Other: _____

These records concern the time between _____ and _____

I fully understand this Authorization and Request to Release or Obtain Records and Information from my records as to the nature of the records, their contents, the consequences and implications of its release, and my request is wholly voluntary on my part. I hereby release the source of these records from any liability arising from their release. I authorize the parties above to talk by telephone about my referral, diagnoses, treatment, and similar topics relevant to the above listed purposes for this release of records. I understand that provision of services is not contingent upon this releasing of records.

I understand that I may revoke this consent at any time except to the extent that action based on this consent has been taken. This consent will expire automatically after one year from the date on which it is signed, or upon the fulfillment of the above purposes.

_____ _____
Printed Patient/Client or Legal Representative Date

_____ _____ _____
Signature of Parent/Guardian/Representative Relationship Date