

**CONSENT TO OBTAIN OR RELEASE CONFIDENTIAL INFORMATION**

Client Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone (home): \_\_\_\_\_ (work): \_\_\_\_\_ Date of birth: \_\_\_\_\_

I, \_\_\_\_\_, authorize Jorgensen/Brooks Group to: (please mark all that apply)

- ( ) **OBTAIN**
- ( ) **RELEASE**

medical, psychological, educational, legal and social information pertaining to the above mentioned individual.

**Person/Agency/Institution, from or for whom records are to be obtained/released:**

Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Purpose of obtaining/releasing information: \_\_\_\_\_

**Information to be obtained/released:**

- Assessment information
- Treatment Plan(s)
- Progress Notes
- Treatment Summary
- Discharge Summary
- In Compliance With Recommendations
- Attendance
- Other \_\_\_\_\_

This release shall be effective for one year, until the \_\_\_\_\_ day of \_\_\_\_\_, 2\_\_\_\_.

Jorgensen/Brooks Group is hereby released from any and all legal liability that may arise from the release of the information requested. I certify that this request for the release has been made freely and voluntarily. I understand that I may revoke this authorization at any time, except that action has already been taken on the consent.

I understand that my records are protected under federal regulations 42 CFR Part 2, governing confidentiality and cannot be disclosed without any written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically in one year from the time this form is signed.

_____ Client Name	_____ Client Signature	_____ Date
_____ Parent/Guardian (if applicable)	_____ Signature	_____ Date
_____ Witness	_____ Signature	_____ Date