Vision, Hope, and Strength for a Better Life

AUTHORIZATION FOR RELEASE OF INFORMATION
For Ongoing Collaborative Service Providers

I, _____, of _____,
(Client's Name) (Client's Address)

Authorize the following cooperating service providers:

Center For Family Services: Program: _____

_____
(Address) (Phone #) (Fax #)

And:

_____
(Name of Organization / Name of Service Provider)

_____
(Address) (Phone #) (Fax #)

To exchange the following information: _____

_____

For the following purpose: _____

_____

I understand that my records are protected under the federal and state confidentiality regulations and cannot be disclosed without my 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.

I further acknowledge that the information to be released was fully explained to me and this consent is given on my own free will.

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

This authorization to release information will expire, if not revoked by me, in one year, or on the following date: _____
(Expiration Date – not to exceed 365 days)

_____ _____
Signature of Client Date Signature of CFS Worker Date

_____ _____
Signature of Parent / Guardian Date Description of Authority (if signing on behalf of client)