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### Release of Information

I, \_\_\_\_\_, hereby authorize the release and disclosure of the following clinical and or therapeutic records for the following purposes:  
{ } Authorization to release information regarding counseling and therapy care and treatment.  
{ } Authorization to release information held under the Drug Office and Treatment Act of 1972 (PL-92255) and the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act Amendments of 1974.  
{ } Authorization to release information related to Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

Please release authorized information between (Agency), \_\_\_\_\_, and:

Specific Information to be released. Initials: \_\_\_\_  
Assessments and Evaluations, Initials: \_\_\_\_  
Continued Care and Treatment, Initials: \_\_\_\_  
Psychosocial History, Initials: \_\_\_\_  
Discharge Summary, Initials: \_\_\_\_

Correspondence (specify):  
Other (specify):

Purposes for which information is to be released:

\_\_\_\_Revocation/Expiration: This release of Information is subject to revocation by the under-signed at any time except to the extent that information has already been disclosed based on authorization contained herein. Unless further limited by a dated stated here (\_\_\_\_), this Release of Information will automatically expire after a period of 180 days from the date signed. I have the rights to receive a copy of this Release of Information upon my request.

Client/Guardian Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Date: \_\_\_\_\_

Therapist Name: \_\_\_\_\_ Signature: \_\_\_\_\_  
Date: \_\_\_\_\_