# AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, the undersigned, _____, DOB _____, authorize Omni Psychotherapy to:

☐ Release Information to:

☐ Receive Information from:

_____ _____
Name/ Title of Person or Organization Telephone

_____
Address

_____
City State Zip

This information will be released for the purpose of:

[ ] Treatment planning and continuing care

[ ] Other

Extent or Nature of Information to be disclosed:

Specification of the date, event or condition upon which this consent expires on _____

I understand that the information from my record is confidential and protected from redisclosure without additional written authorization from me. I understand that this information may contain confidential psychiatric, psychological drug and /or alcohol abuse treatment and may contain confidential HIV (AIDS) related information.

In treatment related to alcohol and/or drug abuse, I understand that my records are also protected under title 42 of the code of federal regulations for alcohol and drug abuse. I also understand that I may revoke this consent at any time, and unless specified above, my consent will expire 365 days from this date if not acted upon prior to that time. This release was fully explained and consent was given of my own free will.

_____ _____
**Client Signature** **Date**

_____ _____
**Parent / Legal Guardian** **Date**

_____ _____
**Witness Signature** **Date**