Request/Authorization to Release Confidential Records and Information

I, _____, authorize the staff from True Places Counseling, LLC to **obtain** or **release** information from and to the following person and or agency.
My date of birth is _____
Person: _____
Agency_____
Address: _____ Phone: (_____)_____
City: _____ State: _____ Zip: _____

For the following purpose(s): ❑ **Further Mental Health Evaluation, Treatment or Care** ❑ **Development of Services** ❑ **Treatment Planning** ❑ **Discharge Planning** ❑ **Emergency** ❑ **Other _____**

❑ **All prior records.**
❑ **Information in the client's records from _____ to _____**

The information to be disclosed is marked by an X in the boxes. ❑ Intake Summary ❑ Mental Health Assessment ❑ Substance Abuse Evaluations ❑ Progress Notes ❑ Treatment Plans ❑ Discharge Summary ❑ Other: _____.

Please note: HIV-related information contained in these records will be released under this consent unless indicated here: ❑ **Do not release.**

Please forward the records to: **True Places Counseling, LLC; 190 Broad Street, New London, CT 06320**

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may revoke this consent at any time by signing the **CANCELLATION/REVOCATION** section below, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 120 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____	_____	_____
Signature of Client	Print name	Date
_____	_____	_____
Signature Legal Representative-(if needed)	Print name / Relationship	Date
_____	_____	_____
Signature of Witness	Print name	Date
❑ **CANCELLATION/REVOKATION**	_____	_____
	Signature of Client or Legal Representative	Date