



A Division of the Center for Rural Psychology
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Authorization to Release Confidential Information to Family Members/Pastors

This form when completed and signed by you, authorizes me to release protected information about you to the person you designate. I understand that the purpose of this release is to assist with my treatment by improving communication between professional service providers or agencies and the important individual(s) in my life. To further this goal, I authorize my counselor _____, to release the information specified below regarding me to the individual(s) listed below, and to receive information from them.

The information to be disclosed is marked by an x in the boxes below, and the items not to be released have a line drawn through them:

- | | | |
|--|---|--|
| <input type="checkbox"/> Name of therapist | <input type="checkbox"/> Name of case manager | <input type="checkbox"/> Name(s) of treatment program(s) |
| <input type="checkbox"/> Admission/discharge information | <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Scheduled appointments |
| <input type="checkbox"/> Compliance with treatment | <input type="checkbox"/> Discharge plans | <input type="checkbox"/> Verbal treatment summary |
| <input type="checkbox"/> Other: | | |

This information is to be disclosed to these persons, who have the indicated relationship to me:

_____	_____
Name of person	Relationship
_____	_____
Name of person	Relationship
_____	_____
Name of person	Relationship

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire on 1 year from this date, upon my discharge from treatment by this agency or by the person specified above, or under these circumstances: _____

_____	_____	_____
Signature of patient	Printed name	Date
_____	_____	_____
Signature of parent/ guardian/representative	Printed name	Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____	_____	_____
Signature of witness	Printed name	Date

- Copy for patient or parent/guardian Copy for provider/therapist/case manager Copy for family member