Authorization to Release Confidential Records and Information

* Indicates a required field

Monarch Counseling
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Request Authorization to Release Confidential Records and Information (Adults)

* Name of the person who the confidential information being released is regarding:

_____

Birthdate of the person whose confidential information is being released:

_____

* Name of Person or Facility I hereby authorize the release of confidential records and information to:

_____

* Address of Person or Facility:

_____

*I give authorization to: (select all the apply)

- Release information to Tina Schneider, Ph.D
- Receive information from Tina Schneider, Ph.D

* Purpose of the confidential information being released:

- Mental Health Evaluation
- Treatment Planning
- Care
- Other

* Please list the dates between which you consent to confidential information being released

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* Please select the information to be disclosed (select all that apply)

- Intake and Discharge Summaries
- Mental Health Evaluations
- Progress Notes
- Treatment Summary
- Medical History and Evaluations
- Developmental and/or Social History Testing Results
- Other

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here

- Do not release HIV-related information
- Do not release drug and alcohol information

I have had explained to me and fully understand this request-authorization to release records and information, including the nature of the records, their content, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

Note to Recipient

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and/or state law. In accordance with federal and state law requirements, this information received pursuant to this document is confidential and recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug patients.

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* Signature of Client or Client Representative

I consent to sharing information provided here.

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* Printed Name

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* Date