Hope Springs Behavioral Health

Consent to Release Information

I____, hereby authorize

______________________________________ of Hope Springs Behavioral Health

To release/exchange Information to______________________________________

Information to be included: (Check all appropriate box(s))

- o Whether the client is or is not in treatment
- o Client's Prognosis
- o The nature of the project
- o A brief description of the client's progress
- o A short statement as to whether the client has relapsed into drug and alcohol abuse and the frequency of such relapse

This information is confidential as required by law and agency practice for the purpose of

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This consent is subject to revocation at any time, except to the extent that the person/program, which is to make the disclosure by already acted upon it. If not previously revoked, this consent will expire 6 months from discharge or on the following indicated date______________________________

The following information disclosed from records whose confidentiality is protected by Federal and State laws. Federal regulations (42 CFR Part 2) prohibit any further disclosure of this information without the specific written permission of the person to whom it pertains or otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is not sufficient for this purpose.

I have been offered and

- o Accepted
- o Refused a copy of this form

______________________________________ __________________

Client's Signature (or person authorized to sign in lieu of client) Date

______________________________________ __________________

Therapist's Signature Date