LANDSTROM CENTER

CONSENT TO RELEASE/RECEIVE OF CONFIDENTIAL INFORMATION

I _____ authorize Landstrom Center to communicate directly with the agency listed below regarding ☐ **myself**. or ☐ **my child**, _____ , in regards to:

_____.

☐ HIV/AIDS related treatment ☐ Mental Health Information ☐ Psychology Notes

☐ Sexually Transmitted Diseases ☐ Drug/Alcohol Diagnosis ☐ Treatment/Referral/Consultation

☐ Other: Neuropsychological Testing

AUTHORIZED AGENCY OR PERSON: _____

Phone: _____ Fax: _____

Address: _____

FOR THE PURPOSE OF:

☐ Continuing Mental health/alcohol and/or drug abuse

☐ Treatment or care and continuity of care /Therapist transition

☐ Housing and other arrangements and services

☐ Billing, payment and financial matters

☐ Consultation, advise and representation

☐ Other _____

_____

This consent is valid until (Calendar Date): _____

I understand that I have the right to inspect and copy the information to be disclosed and may revoke this authorization at any time. Any such revocation will not affect materials disclosed prior to the revocation. The above-named person authorized to receive this information may use the information only for the purposes outlined above and may not redisclose it without my written authorization

I also understand that if I refuse to consent to the release of information the following may occur: _____

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Signature of Staff/Witness Date

NOTICE TO PATIENT AND RECEIVING AGENCY

Under the provisions of the Mental Health and Developmental Disabilities Act, HIPPA, and applicable Federal and State Alcohol and Substance Abused Confidentiality Acts, there may not be re-disclosure of any of the information provided pursuant to this release unless the patient, and/or parent of the patient who is a minor, specifically authorizes such disclosure.