AUTHORIZATION TO RELEASE INFORMATION

Name _____ Phone _____
Last Name First Name (Please insert both country and area codes)

Address _____
House/Apartment Number Town State/Province

_____
Postal/Zip Code Country

The above named party is hereby authorized ◯ to release ◯ receive ◯ exchange information regarding

_____ SS/SI/NI# _____

◯ to ◯ from ◯ with Bosede Santos for the purpose of _____

_____

Information to be exchanged may include:

☐ Social History ☐ Medical diagnosis/info. ☐ Psychiatric diagnosis/info.

☐ Test Results ☐ Job Performance ☐ Other_____

I understand that all client information is confidential and that my records, with respect to alcohol and drug use, are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my revocation, this authorization will automatically expire:

◯ Upon receipt of the information requested
◯ After six months (60 days for alcohol and drug abuse records) from the date of signing
◯ Under the following condition _____

I further acknowledge that the information being released was fully explained to me and that this consent is given of my own free will.

Client's signature_____ Date_____
(mm/dd/yyyy)

Witness' signature_____ Date_____
(mm/dd/yyyy)

Coach's signature_____ Date_____
(mm/dd/yyyy)

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