Soul Care

AUTHORIZATION TO RELEASE INFORMATION

*Client Name:

*Date: DOB: Record Number:

I authorize ___**Soul Care, PLLC**_____ to release information reciprocal to and from:

Name: _____ Title:

Address: _____
(street) (city) (state) (zip code)

Agency/Insurance Company:_ Phone: _(___)_____

Information to be release: __ Verbally ___ In Writing ___ By Fax

Specific Information to be released: **clinical documentation, educational information, discharge summaries and court reports**

Specific Purpose: **To facilitate access to services**

This consent shall be valid until: _____
(date to not exceed one year)

I understand information released regarding my treatment may include information pertaining to psychiatric or psychological treatment, drug abuse and/or alcoholism, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

The information herein disclosed is from records whose confidentiality is protected by regulations (APSM 45-1- State Confidentiality Rules) which prohibit anyone from making further disclosure of it without specific written client consent, or as otherwise permitted by such regulations.

I, the undersigned, authorize release of the above information to the person(s) or agencies listed below. I understand that I have the right to refuse to sign this consent, as well as the right to withdraw my consent to release of information at any time, except to the extent that action based on this consent has been taken. I understand that revocation of this authorization must be submitted in writing to the Director/Designee of SOUL CARE. Furthermore, I understand that eligibility and/or receipt of services is not contingent upon signing this release

*Client's Signature _____ Date _____

*Parent/Legal Guardian _____ Date _____

Witness _____ Date _____