THE VILLAGE NETWORK
CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Client name: _____ Date of Birth: _____

Social Security Number: _____ Other Legal Name(s)_____

I authorize _____
(Name, address of organization)

to release to ☐ or obtain from ☐, or exchange with ☐ The Village Network

THE FOLLOWING INFORMATION: Note: 1) *specify the time frame covered by the following item(s)*, and 2) identify only minimum items necessary to accomplish the identified purpose of release.

- ☐ Treatment Summary
- ☐ Diagnostic Assessment
- ☐ Psychiatric Evaluation
- ☐ Educational Testing
- ☐ Academic Progress
- ☐ School Behaviors
- ☐ Emergency Room Discharge Summary: Date _____
- ☐ Discharge Summary: Date____ ____ __
- ☐ Recommendations
- ☐ Drug/Alcohol Use/Assessment/Treatment Summary
- ☐ Hospitalization Records
- ☐ Medication/Medical Information Probation/
- ☐ Parole/Court Information
- ☐ Lab Result (s): Specify:_____ __ _____

☐ Other (specify) _____

This information is for the purpose of:

_____

This information has been explained to me and I understand that information cannot be disclosed without my expressed written Consent, except as provided for in contracts with certain referral sources, or as otherwise provided for in law or regulations. I understand and acknowledge that this authorization extends to any or all of the record above, which may include Treatment for mental health/psychiatric; drug or alcohol abuse; and/or Human Immunosuppressive Virus (H.I.V.)/Acquired Immune Deficiency Syndrome (AIDS); and other infectious disease(s) test results or diagnosis. Consent for this release expires within **180** days from date of signature unless otherwise specified. A photocopy of the Release of Information is as valid as the original. Signing or refusing to sign will not affect my eligibility for services. I am entitled to a copy of this form.

There is no guarantee that, if I release confidential information to a person, program or agency that is not bound by federal and state privacy regulations, my information will not subsequently be re-disclosed and lose the protections currently afforded it.

Specific expiration date, if to expire sooner than 180 days:_____
Initials: _____

Signed:_____

_____
Relationship (if other than client)

_____
Printed name of staff facilitating request

Staff Signature:_____

Date:_____

Client Signature:_____ Date:_____
(if AOD client, and over age 14)

_____

Client or parent/legal guardian may revoke this agreement at any time except to the extent that action has already been taken, by providing written notification to The Village Network:

I, hereby, revoke consent of this agreement:

Signed:_____

Date:_____

_____
Relationship (if other than client)

Notice: Prohibition on Disclosure:
This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Parts 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug abuse client.