I, _____ _____ _____

Client's Full Legal Name | Social Security Number | Date of Birth

Authorize Bacon Street Youth and Family Services to

❑ Disclose to:

❑ Receive information from:

_____

Name of Individual and/or Organization to Whom Disclosure is to be made

_____

Street Address | City | State | Zip Code

The following information for dates of service from: _____

❑ Discharge Summary
❑ Substance Abuse Information
❑ Lab Results
❑ Psychiatric Consults / Notes
❑ Medication(s) Prescribed
❑ Diagnosis
❑ Progress Notes
❑ Treatment Plans
❑ Psychological and/or Psychiatric Testing
❑ Other (specify):

❑ Medical History & Emergency Medical Information
❑ Intake Summary / Mental Status Assessment
❑ Social History & Behavioral Observations
❑ Verbal / Written Information Regarding Progress in Treatment
❑ All Confidential School Information (Education Eval. Reports & IEP)
❑ Psychological and/or Psychiatric Testing
❑ Other (specify)

The purpose for the disclosure of this information:

❑ Treatment planning, Coordination of Services
❑ Billing for Services

As the person signing this consent, I understand that I am giving my permission to the above-named provider to disclose my confidential health care records. I also understand that I have the right to revoke this consent at any time, except to the extent that action has been taken in reliance on it, but that my revocation is not effective until delivered in writing to the person who is in possession of my records. If not previously revoked, this consent will terminate one (1) year from the date of signature or until no longer reasonably necessary to accomplish the purpose for which it is given. If there are NO changes to the above information this consent may be extended from the original date by re-signing the second line below.

1 _____ _____ _____ _____

Client Signature | Date | Parent / Guardian Signature | Witness

2 _____ _____ _____ _____

Client Signature | Date | Parent / Guardian Signature | Witness

Note: Photocopies and faxes of this form may be accepted in lieu of the original

Notice to the recipient of this information redisclosure prohibition. This information has been disclosed to you from records that confidentiality may be protected by Federal Law Federal Regulation (42 CFR part 2) prohibits the receiving agency from making further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The federal rules restrict any use of the information to investigate or prosecute any alcohol or drug abuse patient.