

Authorization for Release of Confidential Information

I, the undersigned, hereby authorize **Christina Kontos, LCSW** to release or receive the protected information described below from my child's clinical file to the person designated below:

<p>_____ Assessment _____ Diagnosis _____ Psychosocial Evaluation _____ Psychological Evaluation _____ Psychiatric Evaluation _____ Treatment Plan or Summary _____ Current Treatment Update _____ Medication Management Information _____ Presence/Participation in Treatment</p>	<p>_____ Nursing/Medical Information _____ Toxicological Reports/Drug Screen _____ Educational Information _____ Discharge/Transfer Summary _____ Continuing Care Plan _____ Progress in Treatment _____ Demographic Information _____ Other _____ _____ Other _____</p>
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Release to:

Name

Address

City, State, Zip Code

Telephone

Release from:

Name

Address

City, State, Zip Code

Telephone

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: _____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Christina Kontos, LCSW. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

I understand that this authorization is valid for 180 days after the date of my signature. (Information documented in my medical record after the date of my signature will not be released.) I understand that this authorization authorizes the release of all medical records including Psychiatric, Alcohol, Drug Abuse, and AIDS records. The information is confidential and any redisclosure by the recipient is prohibited, unless expressly permitted by the patient or one authorized to act on his/her behalf.

Patient's Name

Date

Parent/Guardian Signature

Date