Family Counseling and Children's Services
220 North Main Street, Adrian, MI 49221
(517) 265-5352

Case No: _____

CLIENT INFORMATION RELEASE AUTHORIZATION

I, _____, _____, _____,
Client Name Soc. Sec.# Birth Date

Authorize Family Counseling and Children's Services staff or its director, designee or records department, to release and exchange information contained in my records to the individual or organization listed below:

1._____
Name and Title of Individual Telephone#

_____
Name and Address of Agency Program

2. Specific type of information to be disclosed:
☐ Assessments Initial _____Psychiatric_____Psychological_____Other_____
☐ Treatment Records/Summaries_____Progress notes_____Quarterly_____
Annual_____Discharge_____
☐ Other_____

3. The purpose and need for such disclosure:
☐ Determine need for an/or type of treatment.
☐ Monitor progress in treatment.
☐ To make a referral for treatment or other services.
☐ To keep family and/or significant others advised of ongoing progresses
☐ Other (specify) _____

4. This release may be revoked at any time. It shall be valid no longer than is reasonably necessary to accomplish the purpose for which it was given. No information will be disclosed to any third party without your consent and signed release. Only the requested information will be made available for the purpose stated and will able treated confidentially.

- ❑ This release becomes effective on _____ and expires automatically in 90 DAYS.
- ❑ This release becomes effective on _____ and expires automatically in ONE YEAR.

Clients Signature: _____ Date:_____

Signature of
Parent/Guardian: _____ Date:_____

Witnessed by:_____

NOTE: Persons or Agencies receiving information released by this form may not further release it without the written consent of the client.