Consent for Release of Confidential Information to Medical Doctors

Client Date of Birth: _____

I _____, hereby
(please print client full name)

authorize Southeast Child & Family Guidance, represented by one of their licensed therapists, to disclose to the following treatment provider verbally or in writing all clinical information about me as may be necessary to permit these providers to monitor the continuity of my care and to inform them of my health status. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

Doctor:_____

Address: _____

Phone: _____

_____ _____
Print name of Client or Legal Guardian of Client Date

_____ _____
Signature of Client or Legal Guardian of Client Date

_____ _____
Witness Date

Notice to Recipient: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2) and/or state law. In accordance with federal and State law requirements, this information received pursuant to this document is confidential and recipient is prohibited from making further re-disclosure of this information to any other person or entity, or to use it for any purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.