ARETE PSYCHOLOGICAL SERVICES, LLC
REQUEST/AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS AND INFORMATION

I hereby authorize: **Arete Psychological Services, LLC,** to release and receive information from records about:

_____, born on, _____, To: _____

Address: _____

_____Phone:_____

for the following purpose(s):

__ Further mental health evaluation, treatment, or care
__ Rehabilitation program development or services
__ Treatment planning __ Research: __ Other _____

These records concern the time between _____ and _____.

The information to be disclosed is marked by an X in the boxes below.

__ Intake and discharge summaries
__ Medical history and evaluation(s)
__ Mental health evaluations
__ Developmental and/or social history
__ Educational records
__ Progress notes, and treatment or closing summary
__ Other: _____

Method of Disclosure (select as many as are appropriate):

__ Verbal (Phone) __ Fax __ Mail__Email

__ Send records to: _____

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: ☐ Do not release.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days by indicating my wish to do so in writing, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____	_____	_____
Signature of client	Printed name	Date

_____	_____	_____	_____
Signature of parent/ guardian/representative	Printed name	Relationship	Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____	_____	_____
Signature of witness	Printed name	Date

☐ Copy for patient or parent/guardian ☐ Copy for source of records ☐ Copy for recipient of records

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