Patient Name:_____ Date of Birth:_____ Pt ID:_____

Behavioral Health Program Release of Information

I understand that a professional counselor has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow a professional counselor to release some of my personal information to certain individuals or agencies.

I, _____, authorize Matthews-Vu Medical Group to share the following specific information with:_____.

For the purpose of:

_____

The information may be shared: __ in person __ by phone __ by fax __ by mail __ by e-mail

Circle what information you are releasing: Clinical, demographic, diagnosis, health and welfare, academic, family, or Other: _____.

Released Party Information:

Name:_____ Title:_____

Phone:_____ Fax:_____

Address: _____ email:_____

I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.

I understand that I do not have to sign a release form. I do not have to allow my therapist to share my information. Signing a release form is completely voluntary. I understand that this release is limited to what is indicated above. That releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from Matthews-Vu Medical Group, and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing. I understand that this release of information authorization expires one year to the date from the date of signature unless otherwise conditioned.

Client Name_____Client Signature_____ Date_____

Parent Name_____Parent Signature_____ Date_____

Witness Name_____Witness Signature _____ Date_____

I, _____Revoke the above release of information.

Name_____Signature _____ Date_____