Caroline B Williams, PhD MP *Prescribing Clinical Psychologist*
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AUTHORIZATION TO RELEASE INFORMATION

CLIENT NAME: _____ **DATE OF BIRTH:** _____

I do hereby authorize Dr. Caroline Williams to: ☐ **Disclose to** ☐ **Exchange with** ☐ **Obtain from**

Name of Organization/Person _____

Address: _____ Phone: _____ Fax: _____

Indicate the type of information to be disclosed by indicating Yes or No for EACH choice below:

Yes	No	**Mental Health Treatment**	Yes	No	**Alcohol/Drug Abuse Treatment**	Yes	No	Progress Notes
Yes	No	Intake Narratives/ASI	Yes	No	Program Attendance/Compliance	Yes	No	Testing & Lab Results
Yes	No	**Drug Screen Results**	Yes	No	Treatment Plan	Yes	No	**HIV Status**
Yes	No	Medical Information	Yes	No	Progress in treatment/Prognosis	Yes	No	Emergency Medical Information
Yes	No	Other specific information to be released			Please specify: _____			
Yes	No	All records (please circle if Yes)						

This information to be released by means of: ☐ Photocopies/mail ☐ Verbal/telephone ☐ Fax

Information to be released is for services during the period of _____ to _____

The purpose of the disclosure is: ☐ Continuity of care ☐ Other (specify) _____

I understand that my records are protected by state and federal confidentiality laws and cannot be disclosed without my written consent unless otherwise permitted by law. I understand that I may revoke this authorization at any time except to the extent that action has already been taken. I have the right to revoke this consent, but revocation will not be effective until received in writing by the person in possession of my records. If you give written consent to re-disclose your information by the recipient, it may no longer be protected by federal or state laws. If not revoked earlier, this consent will expire as specified below, or if not specified, within one year from the date signed.

Date consent expires: _____ or one year from the date of client or legal guardian's signature.

_____	_____	_____	_____
Signature of client, or legal guardian	Date	Signature of Witness	Date

In the case of Substance Abuse Records: This information has been disclosed to you from records protected by Federal Confidentiality Rule 42 CFR, Part 2. The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 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. The federal Rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse client.