CONSENT TO RELEASE VERBAL/WRITTEN INFORMATION

PATIENT: _____ DATE OF BIRTH: _____/_____/_____
(Last Name) (First) (Middle)

ADDRESS: _____ SS #: _____/_____/_____

_____

I, the undersigned patient or legal guardian, hereby authorizes Breaking Free Services to release verbal and/or written information from my confidential patient file to the following:

☐ Family/Significant Other ☐ Facility or Agency Representative ☐ Attorney
☐ Clergy ☐ Therapist or M.D. ☐ Other

NAME: _____ PHONE: _____-_____-_____

ADDRESS: _____ FAX: _____-_____-_____

_____

Information to be released: ☐ Billing Information (incl. dates of office visits)
☐ Patient Records (see exception below)

This right is subject to certain legal restrictions.
It does not apply to psychotherapy notes or information compiled for judicial hearings.

I understand that I have a right to view or get copies of my health information. I understand that the information released may be mental health or substance abuse related. I understand that I will be charged a reasonable cost-based fee for expenses such as copies and staff time.

I further understand that the above consent can be withdrawn by me, in writing, at anytime. I cannot, however, hold exception to actions to have taken place before I withdrew my consent. The information with is being disclosed is from records who's confidentiality is protected by Federal Law. Regulation
42-CRF Part 2 prohibits disclosure without the written consent of the person whom it pertains.

_____ / /
(Patient's Signature) (Date)

_____ / /
(Parent's/Legal Guardian's Signature – if patient is a minor) (Date)

_____ / /
(Witness' Signature) (Date)