Judy Hait, LMFT, PLLC

Counseling for Individuals & Couples AAMFT Approved Supervisor

RELEASE OF INFORMATION

Client: _____ **Birth Date** _____

I authorize to exchange or release the following information to facilitate informed services with Judy Hait:

_____	Information on Previous Treatment	_____	Evaluation Results
_____	Medical Information	_____	Mental Health
_____	Progress in Treatment	_____	Other:

With: Person: _____

Organization: _____

Street: _____

City/State/Zip: _____

Phone: _____ Fax: _____

I understand that this consent expires upon my termination of treatment.

I understand that records containing information about the diagnosis, treatment, or referral of alcohol and drug abuse problems are protected under federal confidentiality regulations (42 CFR, Part 2—Alcohol and Drug) and cannot be disclosed without my written consent. I also consent to the release of that information. _____ (client initials)

I understand that my records may contain information regarding testing, diagnosis, or treatment of HIV/AIDS, or sexually transmitted diseases. I consent to the release of that information. _____ (client initials)

Other parties receiving this information are prohibited from re-disclosing these records, unless expressly permitted by my written consent, unless disclosure is otherwise permitted by federal regulations.

I understand that I can terminate this consent at any time in writing.

_____ _____

Client/Parent/Guardian *Date*

_____ _____

Witness *Date*

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