CONSENT FOR RELEASE AND RECEIVE INFORMATION
To be given to:

Choose Therapist from list

Child, Adult Family Therapy and Consultation Servcices (CAFTACS) Team members

Name: Date of Birth:

Check all that apply: **ONLY INFORMATION CHECKED BELOW IS APPROVED FOR RELEASE**
Extent or nature of information to be disclosed:

☑ Mental Health ☑ Alcohol/Drug ☑ Medical Information

☑ Assessment / Evaluation ☑ Discharge Summary ☑ Treatment Plan / Recommendations

☑ Medical Assessment ☑ Progress Notes ☑ Diagnosis ☑ Educational Testing

☑ Conversation and Written Dialogue ☑ Update Reports ☐ Other_____

Permission is given to share information with and receive information from:

(Therapist Discretion)

Purpose or need for disclosure:

☑ Continuity of Care ☑ Evaluation ☑ Treatment Planning
☐ Other_____

I, the undersigned, have read the above and authorize the practitioner named above to disclose such information as herein contained. I understand that this consent may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. This consent shall expire 6 months from its signing, unless a different time period, event or condition is specified below, in which case such time period, event or condition shall apply. I understand, in the case of releasing substance abuse information, that any disclosure is bound by Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records. I understand, in the case of releasing HIV related information, that any information which could indicate that a person has been potentially exposed to HIV related illness of AIDS, or any information which could indicate that a person has been potentially exposed to HIV under New York State law can only be released to persons you allow to have it by signing a release. I understand that if I sign this form, HIV related information could be given to the people listed on the form for the reason(s) listed on the form. If I experience discrimination because of release of HIV related information I may contact the New York State Division of Human Rights at (212)870-8624 or the New York City Commission of Human Rights at (212)566-5493. Any redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.
Time period, event or condition replacing period specified above:

_____ _____

Patient's Signature (if over 16) / Date Signature of Parent / Guardian Date

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