The Family Resource Center of Southwest Florida, Inc.

Authorization to Obtain and/or Release Information

RE: _____v _____ Case # _____

Client Name: _____ DOB: _____/_____/_____

This form, when completed and signed by you authorizes The Family Resource Center and its staff to obtain and release protected and confidential information regarding you, your clinical records and the services provided to you at The Family Resource Center with the person or agency listed below.

This information may be about ❑ myself ❑ my child(ren) listed below: (Name/DOB)

_____ _____

_____ _____

Information may be ❑ obtained from ❑ released to

Name of agency or person: _____

Address: _____

Phone:_____ Fax:_____

Information To Be Released Or Obtained:

_____

_____

The purpose of obtaining/releasing this information is:_____

_____

I understand that I have the right to refuse to sign this authorization. I further understand that if information other than that listed above is requested, such information will not be released or obtained without my written consent.

This authorization is for a ❑ single, or ❑ continuing disclosure, valid for one year following the date of my signature as it appears below, or until my client relationship with the Family Resource Center terminates, whichever comes first. This authorization may be revoked at any time upon written notification by the client or legal guardian, but revocation has no effect on action previously taken.

This Authorization expires: _____/_____/_____.

_____ _____/_____/_____
Signature of Client Date

_____ _____/_____/_____
Signature of Parent or Legal Guardian Date

_____ _____/_____/_____
Signature of Witness Date