**AUTHORIZATION TO RELEASE INFORMATION**

Client Name:

Date: DOB: Record Number:

I authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release information reciprocal to and from:

Agency: MCR Therapy, LLC Phone: \_(980)-500-9180\_\_\_\_\_\_\_\_\_

Address: 5636 Whitesville Rd Suite D1 Columbus, GA 31904\_

 (street) (city) (state) (zip code)

Information to be release: XX\_\_ Verbally \_XX\_\_ In Writing \_XX\_\_ By Fax

Specific Information to be released:

Specific Purpose: **Evaluation, Diagnosis and Treatme**nt

This consent shall be valid until: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (date to not exceed one year)

I understand information released regarding my treatment may include information pertaining to psychiatric or psychological treatment, drug abuse and/or alcoholism, Acquired Immunodeficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

The information herein disclosed is from records whose confidentiality is protected by regulations (APSM 45-1- State Confidentiality Rules) which prohibit anyone from making further disclosure of it without specific written client consent, or as otherwise permitted by such regulations.

I, the undersigned, authorize release of the above information to the person(s) or agencies listed below. I understand that I have the right to refuse to sign this consent, as well as the right to withdraw my consent to release of information at any time, except to the extent that action based on this consent has been taken. I understand that revocation of this authorization must be submitted in writing to MCR Therapy, LLC. Furthermore, I understand that eligibility and/or receipt of services is not contingent upon signing this release

Client’s Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_