Patrick B. McGinnis, PhD, LMHC

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Authorization to Release or Disclose Confidential Information

1. I**,**_____**,** the undersigned, hereby authorize and request that Patrick B. McGinnis, PhD, LMHC, (and/or the person/agency in #2 below) release, exchange, and/or obtain the following confidential information and/or records:

(√ Check all that apply or specify after Other)

____ My status as a client

____ Psychosocial history, assessment and recommendations

____ Pertinent progress notes

____ Treatment Plans

____ Psychological/psychiatric evaluations

____ Pertinent medical history

____ Other testing results

____ Other _____

_____

2. This information is to be released to, released by, or freely obtained from:

_____

_____

I understand that my records may be protected, in full or in part, under the Federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 43 CFR, Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that this consent is valid for one year or until _____. I understand that I may revoke this consent at any time, either verbally or in writing, except to the extent that the disclosure has already been acted upon. I agree that a faxed copy of this release form is as valid as the original.

_____
Signature & Date

_____
Signature & Date of Parent/Guardian or Authorized Representative if a Minor

_____
Witness & Date