RELEASE OF INFORMATION FORM

To/From:_____
Name of Physician, School, Clinic etc.

_____
Address

_____

Families First Inc., has been authorized to *obtain/disclose* information concerning:

Client:_____Date of Birth_____

The purpose of this *disclosure/collection* is as follows:

1. Intake diagnostic evaluation.
2. Psychological and psychiatric evaluation
3. Social Summary, medical history, substance abuse history.
4. Progress notes and closing summary.
5. Other_____

I understand I may revoke my consent to allow Families First Inc., to *obtain/disclose* information at any time, except to the extent action has been taken on information prior to the revocation of my consent.

_____ _____
Signature Date

_____ _____
Witness Date

This release of Information Form expires 1 year from the date of consent.

34 E. Main Street, PO Box 939, Wilmington, VT 05363
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