RELEASE OF INFORMATION FORM

To:

____

Name of Medical Provider, School, Clinic etc.

From:

____

Name of Individual/Organization asking for information.

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.

Families First
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Fax: 802-275-4922
Email: nurse@familiesfirstvt.org