Name: _____
DOB: _____
XIX#: _____

CONCERNED, INC.
AUTHORIZATION TO OBTAIN OR RELEASE INFORMATION

Name: _____ **Date:** _____

Date Release Expires: _____ **SS#:** _____

I, the undersigned, hereby authorize the Concerned, Inc. staff to release and/or obtain the information indicated below, regarding the above named individual, with:

_____
Name of Person or Agency

_____
Complete Mailing Address

Specific Information Includes the Following:

_____ Social History
_____ Progress/Summary Reports/Periodic Reviews
_____ Incident Reports/Notices of Concern
_____ Discharge Summaries/Exit Contacts
_____ Other: (Or note exceptions here) _____
_____ Educational History
_____ Vocational History
_____ Medical History
_____ Individual Service Plans
_____ Psychological Evaluation
_____ Re-Release of 3rd Party Info (specify) _____

The purpose of the exchange of information is for the planning and implementation of an Individual Service Plan and the coordination and monitoring of services. All information will be disclosed on an *as needed basis.* I understand that all Concerned, Inc. records are confidential and cannot be released without my permission, or that of my guardian's. I understand that if the person(s) or entity (ies) that receives the information is not a health care or service provider, or a health plan covered by federal privacy regulations, the information described above could possibly be re-disclosed and is no longer protected by those regulations. Therefore, I release Concerned, Inc. and its employees, from all liability arising from this disclosure of information. Concerned, Inc. will not disclose any information received from an outside agency with any other party. That information must be obtained directly from the outside agency providing the information.

I further understand that I may inspect or request copies of any information disclosed by this authorization. I understand that the information will be used to assist Concerned, Inc.'s staff in providing quality care and that this information will not be released to any other agency, individual or organization for any other purpose without my written consent except as required by Federal or State law. I also understand that I may revoke this consent at any time in writing to the origination agency (Concerned, Inc.). If I do so, I know that it cannot apply to any information that had been released prior to receipt of my written notice. If not previously revoked, this consent will expire on _____ (Not to exceed one year).

_____ _____
Signature of Client **Date**

_____ _____
Signature of Guardian/Parent **Date**

Specific Authorization for Release of Information Protected by State or Federal Law:
I specifically authorize the release of data and information relating to:

_____ Substance Abuse _____ Mental Health _____ HIV Related Information

_____ _____
Signature of Client **Date**

_____ _____
Signature of Guardian/Parent **Date**

A copy of this Authorization for Release/Receipt of Information has been given to:
_____ Client _____ Parent/Guardian _____ Person/Agency Named Above
_____ Concerned, Inc. files

Date Developed: March 31, 2003
Date(s) Revised: 04/28/03, 1/25/06, 11/10/06, 3/15/07 08/25/10, 3/17/14