STEPPING STONE
FAMILY SERVICES

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name:	Date of Birth:

I understand that Stepping Stone Family Services (SSFS) has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow SSFS to release some of my personal information to certain individuals or agencies.

I, the undersigned, authorize SSFS to release to, secure from, or exchange information with:

Agency/Individual	

The specific information to be shared is:

☐ Yes ☐ No Psychiatric evaluation(s) and record(s)	☐ Yes ☐ No Treatment Plan
☐ Yes ☐ No Psychological evaluation(s) and record(s)	☐ Yes ☐ No Termination/Discharge Summary
☐ Yes ☐ No Educational/Academic Records	☐ Yes ☐ No Psychosocial Assessment
☐ Yes ☐ No Medical Information	☐ Yes ☐ No Mental Health Treatment
☐ Yes ☐ No Verbal Communication	☐ Yes ☐ No Progress Notes
☐ Yes ☐ No Additional Information:	

The purpose for this disclosure is to facilitate effective treatment service coordination. A photocopy or exact reproduction of this form for release of information shall have the same effect as the original. This authorization will automatically expire one year from the date of signature unless a shorter period is specified (specific number of days/months or date): _____
I understand that I may revoke this authorization at any time, except to the extent that information has already been released as authorized by giving written or oral notice to SSFS. I understand that I have the right to review the disclosed information by contacting SSFS. Once this authorization has expired or has been revoked, it can be renewed only by proper execution of another authorization. I acknowledge that information to be released may include material that is protected by state and/or federal law, including applicable mental health, alcohol/drug abuse, HIV/AIDS information, or all of these. I understand that information authorized by this consent cannot be released to anyone than those listed above unless I give written permission. SSFS does not require completion of this form as a condition of treatment, payment, enrollment, or eligibility for benefits.

_____ _____ _____
Client/Guardian/Legal Representative Relationship Date

_____
SSFS Provider, Credentials

Specific authorization for release of information protected by state or federal law: In order for this information to be released, you must sign below. I specifically authorize the release of data and information relating to:

☐ Yes ☐ No Substance Abuse (alcohol/drug use)
☐ Yes ☐ No HIV/AIDS Information

_____ _____ _____
Client/Guardian/Legal Representative Relationship Date

This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.