& 4 Real Solutions 4 Real Life Problems Human Services Agency

Participant Name: _____

Information To Be Released or Exchanged with Anger Management 818 Staff Member/Facilitator:

_____

Name: _____ Your relation: _____

Address: _____

Information To Be Released or Exchanged:

[ ] Attendance Record
[ ] Participation
[ ] Anger Management Modality (Class or Executive Coaching)
[ ]Number of Court-ordered sessions

[ ] Discharge Summary
[ ] Psychiatric Evaluation
[ ] Psychological Test Results
[ ]Chemical Recovery History
[ ] Dates of Hospitalization
[ ] Court/Agency Documents
[ ] Mental Status
[ ] Treatment Plans
[ ] Progress Notes

[ ] Therapist Orders
[ ] Diagnoses
[ ] Crisis Intervention Reports
[ ] Medical Records
[ ] Family Systems Evaluation
[ ] Consultation Reports
[ ] Educational Records
[ ] Educational-Tests and Reports
[ ] Psychosocial Report

Other (specify) _____ This authorization shall become effective immediately and expire in one year. A scanned copy, photocopy, or fax of this form is to be considered as valid as original. Authorization of disclosure of your mental health information to someone who is not legally required to keep it confidential may be redisclosed and may not be protected.

Your Rights:

1. You may refuse to sign this authorization.
2. You have the right to revoke this Authorization by writing to your Facilitator. Your revocation will be effective once it is received by staff of Care 4 His Creation. This revocation, however, will not extend to information that was already obtained or released prior to the revocation.
3. You can receive a copy of this Authorization.

_____ _____

Participant Signature Date

Thank-You from:

& 4 Real Solutions 4 Real Life Problems Human Agency