EastValley
COMMUNITY HEALTH CENTER

Behavioral Health Department

Consent to Release Information

SECTION 1.

Client Name: _____ Date of Birth: _____ MR #_____

Address:_____

City:_____ CA___ Zip: _____ Telephone: _____

SECTION 2.

☐ **I authorize East Valley Community Health Center Mental Health Program to release information to:**	☐ **I authorize East Valley Community Health Center Mental Health Program to obtain information from:**
Name of Provider or Facility	**Name of Provider or Facility**
Address:	**Address**
City, State, Zip	**City, State, Zip**
Phone Number/ Facsimile #	**Phone Number**

SECTION 3. The information applies to the following:

☐ Assessment
☐ Treatment Planning
☐ Case Coordination
☐ Other: _____

SECTION 4. This Release applies to the following:

☐ Reason for Referral
☐ Social History
☐ Diagnostic Information
☐ Treatment Summary
☐ Copy of Initial Assessment
☐ Copy of Coordination & Service Plans
☐ Pertinent Discharge Summary
☐ Other: _____

SECTION 5. Treatment will not be contingent on my providing or refusing to provide this Release. If I do not revoke it earlier, this Release is effective from _____ to _____, and not to exceed a period of:

☐ 90 days from date of consent for a one-time disclosure, OR
☐ 12 months for ongoing services provision by a collaborating service provider.

Client Signature	**Date**
Parent/Legal Guardian Signature	**Date**
Signature of Witness to Above Signature(s)	**Date**