

RELEASE OF INFORMATION

I hereby authorize Jade Mangus, LCSW, to release information from the records of:

Name _____

Date of Birth _____ SSN _____

Aproximate Dates of Treatment _____

I waive my claim of privilege arising out of the doctor/patient relationship with regard to my records of treatment and any/all information pertaining to my association to Jade Mangus, and hereby authorize Jade Mangus, LCSW, to release information to:

Name

Address

I hereby release Jade Mangus, LCSW, from any and all legal liability that may arise from the release of information requested.

The purpose of this disclosure is

Please send the following information:

- | | |
|--|---|
| <input type="checkbox"/> Psychosocial History | <input type="checkbox"/> Psychiatric Evaluation |
| <input type="checkbox"/> Progress Notes/ Summary | <input type="checkbox"/> Collateral Information |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Other |
| <input type="checkbox"/> Alcohol & Drug Assessment | _____ |
| <input type="checkbox"/> Treatment Plans | |

I understand that my records are protected under the Federal Confidentiality Regulation and cannot be disclosed without my written permission. I also understand that my consent for disclosure is subject to my revocation at any time and need only be expressed in writing. Otherwise, this disclosure expires 1 year from the date below.

Dated this _____ day of _____ 20____

Client Signature

Witness

Client's Agent or Representative

Date

Relationship to Client