

WHOLE VILLAGE FAMILY RESOURCE CENTER
OFFICE OF FAMILY SERVICES

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Client Name: _____ Date of Birth: _____

*I understand that all my records are confidential and protected from unauthorized disclosure. I authorize **Whole Village Family Resource Center** to obtain or disclose my protected information as described below to or from:*

The following agencies:

Purpose: Whole Village Family Resource Center is coordinating case management and/or wrap around services for the individual and/or family.

Specific Records to Release or Receive (only check those that apply)

- | | | |
|---|---|--|
| <input type="checkbox"/> Intake Summary | <input type="checkbox"/> Records from outside sources | <input type="checkbox"/> Case Management Notes |
| <input type="checkbox"/> Disability Documentation | <input type="checkbox"/> Medical Notes | <input type="checkbox"/> Legal Documents |
| <input type="checkbox"/> Evaluations | <input type="checkbox"/> Test Results | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Verbal Exchange of Information | <input type="checkbox"/> Education Plans | <input type="checkbox"/> Other _____ |

I HEREBY AUTHORIZE WHOLE VILLAGE FAMILY RESOURCE CENTER TO OBTAIN OR DISCLOSE MY ABOVE MENTIONED RECORDS, INCLUDING SUBSTANCE ABUSE, HIV INFECTION, AIDS OR TESTS FOR HIV.

NOTE: Federal regulations govern the confidentiality of alcohol and drug dependent persons (42 CFR Part 2).

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. A faxed copy of this authorization shall be considered as effective and valid as the original. I accept the risk of misdirected information (release authorization records) via a misdialed phone number.

I certify and acknowledge that this release is signed voluntarily.

I understand this release may be revoked by my sending a **written notice** to Whole Village Family Resource Center and will become effective the date they receive the notice.

This release is valid for a period of one year.

Client Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(If client is under 18)

Witness Signature: _____ Date: _____

Family Services Coordinator Signature: _____ Date: _____



WHOLE VILLAGE FAMILY RESOURCE CENTER
258 HIGHLAND STREET ★ PLYMOUTH, NH 03264 ★ 603.536.3720

