RELEASE OF INFORMATION

Client Name: _____ DOB: _____

I authorize the release of records, including those which may contain confidential HIV/AIDS related information, confidential communicable disease related information, information relating to mental health and/or alcohol/drug use.

I authorize Sunshine Acres Children's Home to **RELEASE/OBTAIN** information or copies of my records **TO/FROM:**

Name of person or agency: _____

Address: _____

Phone: _____FAX: _____

FOR PURPOSES OF:
___ Assessment, treatment planning, and case coordination.

_X_ Possible Placement

___ Other purposes: _____

PLEASE RELEASE THE INFORMATION TO: Sunshine Acres Children's Home
3405 N Higley Rd, Mesa AZ 85215
480-832-2540
FAX 480-999-3495

The following information is requested:

X Intake/Assessment	X Treatment/Progress Summary
X Treatment recommendations	X Psychological / Psychiatric evaluation
X_ Medication (Past/Current)	X Discharge Summary
X Substance Use (Past/Current)	X Probation/Court status __

Other _____

X Risk taking behavior including but not limited to: Alcohol use, drug use, self-injury, purging/ binging, or sexual activity.

This consent shall remain in force for a period of six (6) months from the present date. I understand that this consent is subject to revocation by me at any time in writing, except to the extent that action has already been taken on it.

Parent/Guardian signature: _____ Date: _____

Client signature (if appropriate): _____ Date: _____

Witness Signature: _____ Date: _____