

Request/Authorization to Release Confidential Records and Information

**The Center for Assessment, Inc.
26711 Woodward Avenue, Suite 301
Huntington Woods , MI 48070
(248) 677-0074 * Fax (248) 677-0089**

This authorization is voluntary. I understand that once information has been disclosed it may no longer be protected from further disclosure. I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either verbally or in writing. Revocations will not apply to information that has already been released.

1. Client Name: _____

Street Address: _____

Birthdate: _____ Social Security #: _____

2. I authorize:

**The Center for Assessment, Inc.
26711 Woodward Ave, Suite 301 Huntington Woods, MI 48070
Phone: 248-677-0074 Fax: 248-677-0089**

To:

Release records to: _____ Obtain records from: _____ Share information/records with _____

The following person or organization:

Name of Person/Organization: _____

Address: _____

Phone: _____ Fax: _____

3.

What information about me may be shared:	<i>(List as specifically as possible. For example: name, dates of service, document type.)</i>
Why I want my information shared:	<i>(List as specifically as possible. For example, to receive benefits.)</i>

4. The information may be shared by: phone fax by mail e-mail* in person
* I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by others.

5. HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here:

Do not release HIV-related information Do not release drug and alcohol information.

6. This release expires on: ____/____/____

Signed: _____ Date: _____ Relationship to Client _____

Witness: _____ Date: _____