The MECCA Group, LLC
1050 17th Street, NW, Suite 800
Washington, DC 20006
202-529-3117

Request/Authorization to Release Confidential Records and Information

I hereby authorize:

Person or facility: _____

_____

Address: _____

_____ Phone: _____

to release information from records about _____, born on _____,

and whose Social Security number is _____, for the following purpose(s):

☐ Further mental health evaluation, treatment, or care ☐ Rehabilitation program development or services

☐ Treatment planning ☐ Research ☐ Other: _____

These records concern the time between _____ and _____.

The information to be disclosed is marked by an in the boxes below, and the items not to be released have a line drawn through them. Page numbers are indicated when appropriate. Written dates indicate when those records were mailed to the requester.

☐ Intake and discharge summaries ☐ Medical history and evaluation(s)

☐ Mental health evaluations ☐ Developmental and/or social history ☐ Educational records

☐ Progress notes, and treatment or closing summary ☐ Other: _____

Select only one:

☐ Please forward the records to the address in the letterhead at the top of this form.

☐ Please forward the records to the address written above.

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: ☐ Do not release.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____	_____	_____
Signature of client	Printed name	Date

_____	_____	_____	_____
Signature of parent/ guardian/representative	Printed name	Relationship	Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____	_____	_____
Signature of witness	Printed name	Date

☐ Copy for patient or parent/guardian ☐ Copy for source of records ☐ Copy for recipient of records

FORM 47. Briefer form for requesting/releasing confidential records and information. From *The Paper Office*.