CHILD AND FAMILY THERAPY ASSOCIATES
1121 WESTRAC DRIVE SUITE 204, FARGO, ND 58103
(T) 701-893-3419 (F)701-356-8801

PATIENT NAME_____ **DOB:** _____

Allow Child and Family Therapy Associates to **send to** ☐ **obtain from** ☐ or **exchange information with** ☐ the following:

Name/Agency:_____

Address/number:_____

Information to be released

	Psych Assessment/Testing		**CSI, CTBS, Standardized Educational and Intellectual Testing Results and Reports**		**Emergency Notification**
	Progress Reports		**Admission Reports**		**Rating Scales**
	Diagnostic Assessment/Reports		**Dates of Admit/Discharge**		**Family Involvement**
	Discharge Summary		**History and Physical**		**C.D .Assessment**
	Social, Emotional, Behavioral Functioning, IEP, Grades, Attendance				
	Verbal and Written Exchange				
	School Testing Results/Reports				
	OTHER:				

This information is necessary for:

	Diagnosis and Treatment		**Legal Purposes**		**Emergency Notification**
	Acknowledge Referral		**Coordination/Follow-up**		**Insurance Purposes**
	Update Records		**Education Purposes**		**Social Service Involvement**
	Other:				

I understand that this information may be communicated in written, electronic and/or oral form.
I understand that authorizing the disclosure of this information is voluntary and only I can refuse to sign this authorization.
I further acknowledge that any release of information carries with it the potential for re-disclosure and the information may not be protected by federal confidentiality rules. Chemical dependency rules are further protected by a more stringent Federal Law (42 CFR Part 2). This information cannot be disclosed without the expressed authorization of the patient/client, nor can the information be disclosed unless specifically authorized by the patient/client or as otherwise permitted by CFR Part 2.

I AUTHORIZE THE RELEASE OF CHEMICAL DEPENDENCY, ALCOHOL AND/OR DRUG ABUSE RECORDS THAT ARE PART OF THE RECORDS I SPECIFIED ABOVE UNLESS OTHERWISE INDICATED HERE.
_____DO NOT release records from alcohol and/or drug programs protected by Federal Laws.

I AUTHORIZE ALL RECORDS PERTAINING TO BEHAVIORAL, PSYCHIATRIC/MENTAL, AND OTHER RELATED CONTENT TO BE RELEASED UNLESS OTHERWISE INDICATED HERE.
_____DO NOT release records regarding Behavioral/Mental Health

This consent remains in effect for 12 months from the date of the signature or the date specified _____.
I acknowledge by my signature that I understand that this consent remains in effect until the date or event specified above unless revoked by me in either written or verbal form. A photocopy or fax of this authorization will be treated the same way.

_____ _____ _____
Signature of parent/guardian **Date** **Signature of Patient**

_____ _____
Witness **Date**