PFEIFER & ASSOCIATES

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We are better able to serve you by working with other agencies that know you and your family. By signing this form, you are giving permission for these organizations or individuals to share information about your situation.

Name_____D.O.B._____SS#_____

I authorize **Pfeifer & Associates** to release information to:_____

Phone:_____Fax:_____

I authorize _____ to release information to **Pfeifer & Associates**

(Initial)_____ including records of family history

(Initial)_____ Alcohol/Drug Treatment

(Initial)_____ Mental Health Services

(Initial)_____ Medical/Psychiatric Treatment

(Initial)_____ Educational Reports

Alcohol/drug, mental health, and medical Records include all aspects of diagnosis, treatment, and prognosis. Educational reports include both behavioral and progress reports.

I agree that the agencies and individuals listed above may share and exchange information. (initial) _____ ☐ yes

Purpose: The information received will be used to evaluate my situation and to plan for and coordinate services for me and my family, or for other purposes specified:

_____

This permission is good for one year or until REVOKED IN WRITING.

I may cancel this at any time with a written request, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by State and Federal Law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

☐ Client ☐ Guardian

☐ Parent ☐ Legal Custodian

Signature:_____ Date:_____
Worker Signature:_____ Date:_____

To those receiving information under this authorization: The information disclosed is protected by State and Federal Law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.