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Release of Information

NAME OF INDIVIDUAL: __________________________________ID #: _______

By my signature below, I am authorizing the release, exchange and/or discussion of pertinent social, psychological, medical and/or other information for the purpose of making appropriate referrals for services.

Information may include (please check all that apply)

__________ FINANCIAL

__________ LEGAL

__________ MEDICAL

__________ HOUSING

__________ EMPLOYMENT

__________ MENTAL HEALTH

__________ OTHER (PLEASE SPECIFY) __________________________________

- ANY INFORMATION TO BE RELEASED WILL BE USED SOLELY FOR THE PURPOSES SET FORTH IN THIS RELEASE.
- I UNDERSTAND THAT ALL EMPLOYEES OF SPECTRUM CARE MANAGEMENT AND COUNSELING, LLC WILL TREAT ALL INFORMATION ABOUT ME WITH THE UTMOST CONFIDENTIALITY.
- THIS CONSENT WILL EXPIRE 365 DAYS FROM THE DATE OF MY SIGNATURE, OR SOONER IF SPECIFIED.
- I HAVE VOLUNTARILY AUTHORIZED THIS RELEASE OF INFORMATION.

______________________________	____________________	____________
SIGNATURE INDIVIDUAL/GUARDIAN	PRINT NAME	DATE