Kaleidoscope
THERAPY SERVICES, LLC

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Authorization for Release of Information

Client name: _____

DOB: _____ **Date:** _____

Medicaid ID (if applicable): _____

I, the above named individual/guardian, hereby authorize Kaleidoscope Therapy Services LLC to:

☐Release confidential information ☐Receive confidential information

To/From: _____

Information requested: Please check all that apply

Admission/Assessment/ Evaluation
Drug/Alcohol Evaluation
Medical Records
Court Reports
Treatment plans
Discharge Summary
Child Welfare Case Notes
Other:

Reason:
_____
_____
(Copies may be used in lieu of original)

Automatic Expiration: 1 year from date signed.

Revocation: If you revoke this release in writing, you must clearly state whether the revocation applies only from the date of revocation forward or if it revokes all previously released information for the entire duration of involvement.

_____ _____
Client Signature Date Therapist Signature Date

Release from liability: I understand that my records are protected under the Federal regulations governing Confidentiality 43 CFR Part 2, and cannot be disclosed without written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action had been taken in reliance on it.

NOTICE TO RECIPENT (S) OF INFORMATION: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS, WHICH ARE PROTECTED, BY FEDERAL LAW. REGUALTIONS PROHIBT YOUR FUTHER DISCLOSURE WITHOUT SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS.