



AUTHORIZATION FOR RELEASE OF INFORMATION

Consumer Name: _____, Date of Birth: _____,

Request and authorize: _____

(Name and address of Doctor, School, Hospital, Court, etc)

to release to and/or obtain from: **First Step, Inc., 1755 The Exchange, Suite 260, Atlanta, GA 30339**, the following type(s) of information from my records (and any specific portion thereof):

For the purpose of: _____

All information I hereby authorized to be obtained from or released to this agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for

Ninety (90) days: One (1) year: Unless I specify an expiration date here: _____

If this release is for a court ordered psychological evaluation, it is understood that the report will be used as evidence in court. The psychological evaluation report will be released to the referring agency/attorney and you may request information from that agency/attorney.

It is understood that this consent is subject to revocation at any time by the undersigned except to the extent that action has already been taken in compliance with this consent.

NOTE WHERE INFORMATION ACCOMPANIES THIS DISCLOSURE FORM: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS PROTECTED BY FEDERAL CONFIDENTIAL RULES (42 CFR PART 2). THE FEDERAL RULES PROHIBIT YOU FROM MAKING ANY FURTHER DISCLOSURE OF THIS INFORMATION UNLESS FURTHER DISCLOSURE IS EXPRESSLY PERMITTED BY THE WRITTEN CONSENT OF THE PERSON TO WHO IT PERTAINS OR AS OTHERWISE PERMITTED BY 42 CFR PART 2. A GENERAL AUTHORIZATION FOR THE RELEASE OF MEDICAL OR OTHER INFORMATION TO CRIMINALLY INVESTIGATE OR PROSECUTE ANY ALCOHOL OR DRUG ABUSE PATIENT.

Signature of Consumer (unless under the age of 12)

Date

Signature of Representative/Guardian/Parent

Date

Witness

Date

USE THIS SPACE ONLY IF CLIENT WITHDRAWS CONSENT

Signature of Consumer

Date this consent is revoked by consumer