INTERFAITH PARTNERSHIP
for the HOMELESS

Consent for Release of Information

Client Name: _____

DOB: _____ **SS#:** _____

Extent or nature of information to be disclosed (check all that apply):

- ❑ Any information, oral and written, pertaining to the above-named individual, relevant to the care and assistance being provided by the agency to which it will be disclosed. (_____ client initial if checked)

- ❑ Specific Documents: (please have client initial next to each checked box)

  - ❑ Intake assessment _____
  - ❑ Psychosocial assessment _____
  - ❑ Medical records _____
  - ❑ Other: _____
  - ❑ Treatment plan _____
  - ❑ Discharge Summary _____
  - ❑ Attendance records _____
  - ❑ Other: _____

- ❑ Other: _____ (_____ client initial if checked)

Purpose or Need for Information (check all that apply):

- ❑ Ongoing communication between agencies
- ❑ Information required as part of application process to determine appropriateness for admission.
- ❑ Other_____

Individual/Agency ☐ Disclosing ☐ Receiving Information:

Name:_____ Title:_____

Agency:_____ Phone:_____

Address: _____ Fax:_____

Individual/Agency ☐ Disclosing ☐ Receiving Information:

Name:_____ Title:_____

Agency:_____ Phone:_____

Address: _____ Fax:_____

Signature of person completing form: _____ **Date:** _____

I hereby authorize the periodic release of the above information to the person/organization/facility/program identified above as often as necessary to plan for, provide care, services and treatment. I understand that the information to be released is confidential and protected from further disclosure. The duration of this consent is one year from the date of my signature, unless I specify a date, event or condition upon which it will expire sooner. I understand that I may revoke this consent at any time by notifying my case manager, in writing, except to the extent that action has been taken in reliance on my consent.

Client Signature: _____ **Date Signed:** _____