5001 CR Wood Rd. Gastonia, NC 28056
Phone : (704) 862-0095 |Fax: 888-704-6251
Email: BitofHopeRanch@yahoo.com www.BitofHopeRanch.org

CHA Site Accredited

Authorization for Release of Information

Client Name: _____
DOB: _____

I hereby authorize: **Bit of Hope Ranch Mental Health Counseling** to (mark one or both):

□ RELEASE □ OBTAIN MY MEDICAL/PSYCHIATRIC/OTHER INFORMATION

FROM:
Site Name:_____
Address:_____
Phone Number:_____
Fax Number:_____

I authorize by my initials the following information, as applicable, to be released:
Initial:_____

____ Intake Information or Admission Summary
____ Psychological Assessment and Findings
____ Diagnosis
____ HIV/AIDS Related Information
____ Verbal Communication
____Treatment Plan
____ Psychiatric Evaluation
____ Discharge Summary/Instructions
____ Medication
· Other_____

This authorization will expire on this date: _____ (not to exceed 12 months)

➢ I understand the nature of the information to be released and the need for the release of this information. I acknowledge that my consent is voluntary and that I may revoke, by written request, this authorization at any time except to the extent that the above authorized person(s) has already taken action.

➢ I do not authorize further release to any other party. I further understand that Bit of Hope Ranch and its staff cannot be responsible for the confidentiality of information disclosed after said information has been released pursuant to this authorization, and I hereby release Bit of Hope Ranch and its staff from any liability arising from such disclosure.

_____ _____
Signature of Participant (or parent/guardian) Date

_____ _____
Signature of Witness Date

□ I have requested to revoke this authorization (verbal requests will be honored but signature is requested)

Revised 1/17