



AUTHORIZATION FOR DISCLOSURE GENERAL CONSENT FORM

CLIENT NAME: _____ **DATE OF BIRTH:** _____

I, _____ (client/parent/guardian), authorize Child Abuse Prevention Association (CAPA) to:

obtain information from _____ (person/company name) at
_____ (phone and/or email).

AND/OR

release information to _____ (person/company name) at
_____ (phone and/or email).

The following information from my records: *(Check all that apply)*

- | | |
|--|---|
| <input type="checkbox"/> Social History/Intake | <input type="checkbox"/> Verification of Group/Class Completion |
| <input type="checkbox"/> Treatment Goals Summary | <input type="checkbox"/> Discharge/Transfer (Therapeutic) Summary |
| <input type="checkbox"/> Psychotherapy Notes* | <input type="checkbox"/> Progress in Treatment |

(*Cannot be combined with any other disclosure)

- Presence/Participation in Services

and/or list specific information below:

- Other *(specify)* _____

The purpose for this disclosure request is: to coordinate services, aid in treatment, and/or

_____.

Treatment/program services or payment for services is not contingent on signing this Consent Form.

The consent to disclose information from my records may be revoked in writing by me at any time. I understand that CAPA is not liable for any information released prior to the revocation and during the time this consent was in effect. This consent terminates on _____ (date). If the date is left blank, this consent will automatically terminate one month after my file is closed with CAPA. I can revoke this consent at any time in writing or by signing the revocation below.

Form of Disclosure:

Unless I have specifically requested in writing that the disclosure be made in a certain format, CAPA reserves the right to disclose information as permitted by this authorization in any manner that the agency deems to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rule prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by (42 CFR Part 2). CAPA cannot be responsible for or protect from any redisclosure.

Revocation

I, _____ (client, parent, guardian), hereby revoke this Authorization for Disclosure on _____ (date).

Signature of Client/Parent/Guardian

Date

Signature of Client/Parent/Guardian

Date

Signature of Personal Representative

Date

If you are signing as personal representative of an individual, please describe below your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____ Check here if client refuses to sign authorization.

Signature of Staff Witness

Date