



Release of Information: _____ (Student Name) _____ (Date of Birth)

_____ and/or _____ authorize (Name of Student) (Name of Parent or Guardian)

_____ to disclose information to _____ (Releasing Agency) (Receiving Agency Name)

_____ (Receiving Agency Address)

The information subject to this request will not to be released to any other agency, institution, or individual without my signed consent. This disclosure of records is required for quality management purposes to confirm the aftercare received following hospital discharge for the above named student. The level of disclosure shall be limited specifically to the counseling session conducted as a result of discharge from a hospital. Therapy notes will not be requested and will not be released by the Provider in conjunction with this request.

(Signature of Parent/Guardian) (Date) (Signature of Parent/Guardian) (Date)

(*Signature of Student) (Date) (Signature of Counselor/Therapist) (Date)

I understand that I may withdraw this authorization at any time by marking and signing the revocation below on the original signed copy of this form located in my clinical file.

Unless otherwise revoked, this consent terminates on _____ (specify date) or upon the identified student's discharge from Cenpatico.

REVOCACTION: (ONLY sign below if you wish to cancel / revoke the ROI)

The revocation will be effective from the date of signature, and will not apply to any action taken prior to this signed revocation. I REVOKE this authorization ON:

(Signature of Parent/Guardian) (Date) (*Signature of Student) (Date)

**If a student is between 12-18 years of age, both his/her signature is preferred along with required signature of parent/legal guardian.*