



# Jewish Family Service

## CONSENT FOR RELEASE OF INFORMATION

It is the policy of Jewish Family Service to hold all information received from or concerning clients in the strictest confidence. Jewish Family Service will not voluntarily release, obtain or exchange any information without permission of the client.

This document authorizes the release of confidential information about you to the person or entity stated and for the purpose stated. If you have any questions about the form and how it is used, please ask your counselor.

I, \_\_\_\_\_, hereby authorize \_\_\_\_\_  
of Jewish Family Service, and \_\_\_\_\_

to disclose and/or **exchange** records **and information** regarding \_\_\_\_\_  
Client(s) Name(s)

The purpose of this communication is:

- Diagnostic Evaluation
- Coordination of Services
- Other \_\_\_\_\_
- Treatment Planning

And shall include:

- Telephone Calls
- Psychological Reports
- School Reports
- Medical Records
- Other \_\_\_\_\_
- Written Reports
- Test Data
- Treatment Summaries
- Progress Notes

This client last received services in your facility in \_\_\_\_\_, \_\_\_\_\_.

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon.

This release will expire one year from the following date.

\_\_\_\_\_  
Client's Signature

Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent, Guardian or Legal Representative

Date \_\_\_\_\_