Name-Individual Who is Subject of Record	Date of Birth	**COMPREHENSIVE COMMUNITY SERVICES CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION**
Address	City, State, Zip Code	
Name and Address of Person/Agency Authorized to Release and Receive Information: Click here to enter text.	Name and Address of Person/Agency Authorized to Release and Receive Information:	

Specific Records Authorized for Release:

☐ Complete copy of the medical records specified below:

☐ Immunization records ☐ Diagnostic and treatment records ☐ Discharge summaries

☐ Lab reports ☐ HIV/AIDS diagnostic and treatment records ☐ Outpatient notes

☐ Other (specify):

☐ Alcohol and drug abuse evaluation and treatment records

☐ Mental health diagnostic and treatment records including attendance, progress, goals, impressions and recommendations

☐ Vocational records

☐ Human services/Social services records

☐ Child protective services records; Juvenile justice services records

☐ Juvenile court records

☐ Education records, including attendance, behavior, progress, pupil, and Individual Education Plan (I.E.P.) records

☐ Law enforcement records

☐ Other (specify):

This consent will expire on the earliest of the following:

☐ One year from the date of the signature below

☐ On the following date:

☐ After the following event takes place:

Purpose for Release of Information:

To permit communication related to my CCS Plan to take place between the members of my CCS Team and other treatment providers/individuals.

Right to Copy and Inspect: If records regarding medical treatment or treatment for mental illness, developmental disabilities, alcoholism, or drug abuse are disclosed pursuant to this authorization, you may have the right to inspect and, upon paying any applicable fees, obtain a copy of the records disclosed.

Voluntary Consent: My consent to the release of the confidential records described above is voluntarily given. Refusal to sign this authorization may affect my right to receive CCS Services.

Right to revoke: I understand that I may revoke this authorization at any time, except where information has already been released pursuant to this authorization, by sending a written notice of my revocation to the individual/agency hereby authorized to release information. Unless so revoked, this authorization will remain in effect until the expiration event indicated above.

As evidenced by my signature, I hereby authorize disclosure of the confidential records described above to the person(s) or agency(s) specified above. Information disclosed may be subject to redisclosure if the person or entity named is not a health care provider subject to confidentiality laws.

Signature – (Subject of Record)	Date Signed

Signature – (Parent, Guardian, or Authorized Representative)	Date Signed	Title or Relationship to Individual who is Subject of Record