| Guardian Angel Healthcare, LLC. | Facility: |
|---|---|

## CONSENT to RELEASE INFORMATION

Name:

Address:

DOB:

I authorize Guardian Angel Healthcare to release the specified information in my consumer record to: _____

This information shall include:

_____Psychological Evaluation(s)
_____Psychiatric Evaluation(s)
_____Screening(s)
_____Client Profile
_____Diagnosis
_____Service Plan
_____Progress/Grid Notes
_____Other/Disclosures made regarding_____
_____Complete file documentation
_____Medication Information
_____Dates of attendance; types of service

(Person giving consent to initial each person/agency/organization listed.)

The purpose of the disclosure is for:

____Assist with treatment ____Referral _____At request of Consumer _____Financial
____Other_____

**This consent is valid for one (1) year from the date of signature.**

**I HAVE READ THIS INFORMATION AND UNDERSTAND THAT THERE ARE STATUTES AND REGULATIONS PROTECTING THE CONFIDENTIALITY OF AUTHORIZED INFORMATION. I HEREBY ACKNOWLEDGE THAT THIS AUTHORIZATION IS TRULY VOLUNTARY AND THAT I AM THE PROTECTED CONSUMER OR AM AUTHORIZED TO ACT ON BEHALF OF THE CONSUMER TO SIGN THIS DOCUMENT. I FURTHER ACKNOWLEDGE THAT THIS CONSENT IS SUBJECT TO REVOCATION AT ANY TIME AT THE REQUEST OF THE CONSUMER/RESPONSIBLE PERSON EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON THE CONSENT. I UNDERSTAND THAT I MAY REQUEST A COPY OF THIS AUTHORIZATION ONCE IT HAS BEEN SIGNED.**

_____ _____
Signature of Person Giving Consent Signature of Witness

_____
Date