Treasure Coast Homeless Services Council, Inc.

CLIENT CONSENT FOR RELEASE OF INFORMATION

CLIENT NAME: (first, middle, last)____

DATE OF BIRTH:___________________________SOCIAL SECURITY NO.:________________________________

In accordance with Federal Regulation Code 42, Part 2, I hereby authorize:
To release to/share with:

TCHSC, Inc
2525 St Lucie Ave
Vero Beach, FL 32960
772-567-7790

The following information: (including patient records related to any attempted suicide, emotional illness, psychological services records, if any, social services records, if any; including communications made by me to a social worker, counselor, psychologist, physician, or other health care provider; and information regulated by Federal Public Law 93-282, confidentiality of alcohol and drug abuse patients and records documenting the diagnosis and/or treatment of communicable diseases and/or serious disease and infections as defined by the US Department of Health and Human Services rules which include venereal disease, tuberculosis, AIDS, ARC, HIV status and other related diseases, if any)

The following information:

__Diagnostic/Test Results
__Medical Records/Hospital Records
__Psychological/Physhosocial Assesments
__Substance Abuse AssessmentEvaluations/History
__Psychiatric Evaluation/Consultations/Medications
__Diagnostic Impressions/Prognosis
__Discharge/Treatment Summary
__Police/Prison Records
__Financial Information
__Housing Requirements
__Transportation Requirements
__Nutritional Requirements

__Other (please describe):____

for services covering the dates from :____________to ____________for the specific purpose of ____. I release the above cited individuals or facilities of any legal liability that may arise from the release of the information requested. I understand that the agency cannot release information obtained from other sources. I understand that the individual/institution/agency receiving this information may not re-release it to any other individual, institution or agency. I also understand that this authorization for release of information will expire on _______________ unless indicated below:

(not to exceed 1 year)

Condition,date or event of earlier expiration____
I also understand that this release can be revoked, by me at any time and that the revocation must be signed and dated by me, and that the revoking of the release will not affect information released prior to the revoking of the release.

____________________________________ ____________________ ________________________________
Head of Household Signature Date Relationship (if minor)

____________________________________ ____________________
Spouse/Significant Other Date

____________________________________ ____________________________________ ____________________
Witness Name (Print) Witness Signature Date

****I hereby revoke my consent for the release of the previously stated information****

____________________________________ ____________________ ________________________________
Signature Date Relationship (if minor)