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| **Person Served Name:**  | **Avatar ID Number:**  |
| I hereby give consent and authorize Enter Program Name to release and/or exchange information to the following: |

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| **EMERGENCY CONTACTS** |
| **Contact Name:** Enter Contact Name |
| **Relationship to Person Served:** Enter Relationship | **Contact Phone:** Enter Contact Phone |
| **Contact Name:** Enter Contact Name |
| **Relationship to Person Served:** Enter Relationship | **Contact Phone:** Enter Contact Phone |
| The specific TYPE OF INFORMATION to be disclosed and the specific PURPOSE AND NEED for such disclosure is limited to emergency situations. This authorization will remain in effect for one year from the date of signature or until termination of treatment, whichever occurs first. I understand that my records are protected under the Federal and State law and cannot be disclosed without my written consent unless otherwise provided by law. I further understand that the specific type of information to be disclosed may, if applicable, include: diagnosis, prognosis, and treatment for physical, mental and/or emotional illness, including treatment of psychiatric, alcohol or chemical dependency for any admission; diagnosis, prognosis, testing for and/or treatment for HIV infection, Acquired Immunodeficiency Syndrome (AIDS) or Acquired Immunodeficiency Syndrome Related Complex (ARC).  I understand that this consent may be revoked at any time by submitting a written and dated notice of revocation to the agency releasing this information. (Unless release of information has taken place)  |

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| **Person Served Name Printed:**      | **Person Served Signature:** | **Date:** |
| **Counselor/LPHA Name Printed:**      | **Counselor/LPHA Signature:** | **Date:** |
| **Parent/Guardian Name Printed (Optional):**      | **Parent/Guardian Signature (Optional):** | **Date:** |

**\*A Release of Information must be completed for all contacts listed on this form.**