Families First Therapy, LLC

GENERAL CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

CLIENT NAME: ______________________________ DATE OF BIRTH: ________________

THIS WILL AUTHORIZE: Families First Therapy, LLC

Tel. (505) 504-5449; Fax (844) 840-7345

TO RELEASE TO: ______________________________
(Facility, organization, individual receiving information)

____
(Telephone, fax, address)

In authorizing this release of information, I understand it will be used solely for the purpose of: ________both now and in the future.

I specifically authorize the release of my medical records to include the following records (initial):

__________ HIV / AIDS results and treatments
__________ Sexually transmitted or "communicable" disease Information
__________ Prescription Drug Information
__________ Drug, alcohol, or substance abuse Information
__________ Mental health Information (other than psychotherapy notes)

I understand that I have a right to meet with my clinician to inspect my mental health records and any information that will be disclosed. I further understand that this information cannot be re-disclosed without my express authorization. I understand that I may revoke this consent at any time except to the extent that action has already been taken.

This authorization shall remain valid for one year from the date of signature unless revoked in writing by the client's guardian or conservator. This authorization releases Families First Therapy, LLC from any and all legal liability that may arise as a result of compliance with this release of information request.

TO THE RECEIVING PARTY OF THE INFORMATION: This information has been disclosed to you for the SOLE PURPOSE STATED IN THIS CONSENT. Any other use of this information without the express written consent of the client is prohibited. These records may be protected by Federal Regulation (42 CFR Part 2).

My signature below attests to the fact that I have read this form, understand its content and request that the above information be released as specified.

______________________________ ________________
CLIENT SIGNATURE (14 YEARS OR OLDER) DATE

______________________________ ________________
PARENT /GUARDIAN (IF APPLICABLE) DATE

I have discussed the above form and what information may or may not be disclosed with the client(s) and/or their parent/guardian (if applicable). My observations of their behavior and responses give me reason to believe that this person is fully competent to give informed and willing consent. My signature below attests to this statement.

______________________________ ________________
KRISTIN LICHTLE, MA, PA DATE

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