



ellie FAMILY SERVICES

www.elliefamilyservices.com

main 651.313.8080 fax 651.433.7122

Release of Information Consent Form

I, _____, D.O.B. _____, authorize Ellie Family Services to:

Disclose to: _____

Obtain from: _____

Phone: _____ Fax: _____

Exchange with the following individual(s) or entity (ies) _____

The following information:

Diagnosis Psychological Evaluations Discharge/Treatment Info

Social History Provider/Hospital Records School/Criminal Records

Other _____

I understand that all information about me is private. It cannot be shared with anyone without my permission unless the law says it can. I understand that I may refuse to give my permission to share this information. If I refuse, I may not receive the services I am requesting.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME BY EXPRESS WRITTEN NOTICE TO ELLIE FAMILY SERVICES, PLLP., EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON IT OR INFORMATION HAS BEEN RECEIVED AS A RESULT OF IT.

This form will expire automatically:

1 Month 3 Months 6 Months 12 Months

Upon receipt/submission of requested data

I understand that this information will be given only to people who need it to do their jobs. The information will be used only for the reason stated above.

Client Signature: _____

Date: _____

Signature of Legal Representative: _____

Date: _____