www.elliefamilyservices.com
phone: 651.313.8080 fax: 651.925.0610

Release of Information Consent Form

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

☐ Disclose to: ____

☐ Obtain from: ____

☐ Exchange with: ____

Phone: ____________________________ Fax: ____________________________

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: ________________