

**Cullen Center for Children, Adolescents and Families**  
2150 West Central Avenue, 2<sup>nd</sup> Floor  
Toledo, OH 43606

**Authorization to Release/Obtain Information**

**Client Name (first, middle, last):**

Name at time of treatment (if different from above):

I hereby authorize **The Cullen Center for Children, Adolescents and Families:**  To obtain from  To release to

Name of individual and/or institution:

Address (city/state/zip/phone/fax):

The following information (list **specific** reports, types of information):

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Diagnostic information            | <input type="checkbox"/> Case plans               | <input type="checkbox"/> Treatment plans            |
| <input type="checkbox"/> Case plan/ Treatment plan updates | <input type="checkbox"/> Psychiatric evaluations  | <input type="checkbox"/> Individual session content |
| <input type="checkbox"/> Psychological evaluations         | <input type="checkbox"/> Verbal case consultation | <input type="checkbox"/> Medication information     |
| <input type="checkbox"/> Other information:                |   |   |

For services from:  Intake to  Case Closure **OR** Date: \_\_\_\_\_ to Date: \_\_\_\_\_

**SPECIFIC PURPOSE FOR DISCLOSURE:** (check one or more):

- Comprehensive treatment  family involvement  aftercare/follow-up  legal issues  other:

**I understand that I have the right to request an accounting of disclosures made based upon this consent and** that I may revoke (take back) or request an amendment (change) to this consent at any time except to the extent that action has been taken in reliance on it and that consent will expire upon one year from the date shown below or upon the occurrence of the event or condition specified below:

By signing this form, I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include treatment for physical and mental illness, and/or alcohol/drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the results of an HIV test or the fact that an HIV test was performed. I consent to the disclosure of information about me as described and, in the event that the person or agency noted above is an attorney, I consent to such disclosures of that information as may be incidental to use of that information in litigation in which I am a complaining witness or to which I am a party.

\_\_\_\_\_  
Client/ Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date/Time

\_\_\_\_\_  
(2<sup>nd</sup> Staff Signature if consent obtained via phone)/Date/Time

**The confidentiality of these records is protected by federal and other law. These copies are intended exclusively for the requested purposes and cannot be recopied or redistributed for other purposes without the written informed consent of the person to whom it pertains.**