### Release of Information

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Client Name), or (Parent/Guardian of) \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Client Name), [**Client’s Birth Date**] \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize the use or disclosure of my (ward’s) health information as described in this authorization by The Mahogany Projek, LLC to:

**[ ]  Disclose information to [ ]  Receive information from [ ]  Exchange information with**

**Specific person(s)/organization authorized to receive and use the information (list the name and address of the party or entity you want to have access to the information:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Specific and meaningful description of the information to be disclosed or used:**

[ ]  Attendance information
[ ]  Summary of treatment
[ ]  All treatment records
[ ]  Withdrawal/Readmission recommendation

[ ]  Assessment/Evaluations

[ ]  Medication

[ ]  Financial Information

[ ]  Diagnosis

[ ]  Discharge Summary

[ ]  Screening

[ ]  Progress Notes

[ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Purpose of the request** (Please state the purpose of the request. If you do not wish to state a purpose, please state, “At the request of the individual.)”: and no other purpose unless otherwise directed or allowed by law or a court of competent jurisdiction. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Right to Revoke** (non-substance abuse related records): I understand that I have the right to revoke this authorization at any time by notifying the The Mahogany Projek, LLC administrator or Director in writing at: shardeo.gray@themahoganyprojek.com. I understand that the revocation is only effective after it is received in writing by the person who is in possession of my records and except to the extent that the person receiving this authorization takes action in reliance on this consent. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation. **Right to Revoke** (substance abuse related records): I understand that I have the right to revoke this authorization at any time by notifying TMP in writing: I understand that if I desire to revoke my consent before any above-styled cause or court action set forth in section 2 above is final and/or otherwise concluded, I must move the court to so revoke any order to which this consent was or may have been given and I fully acknowledge that the determination of whether such revocation is proper is out of my control. I understand that if I was mandated into treatment, this authorization will remain in effect and cannot be revoked by me until there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment.

*I understand that after this information is disclosed, federal law might not protect it and the recipient might redisclose it.*

*I understand that my initial and continued receipt of services from TMP is not subject to my agreement to this authorization, or any additional authorization that TMHP requests.*

*I understand that I am entitled to receive a copy of this authorization.*

*I understand and fully acknowledge my right not to have this information disclosed. I understand the potential consequences of having this information disclosed. I hereby represent and warrant that in authorizing such disclosure, I have not been induced or coerced in any manner. I hereby release the Mahogany Projek, LLC and its employees, agents, and representatives from any and all liability which may result from my execution of this release and my causing my information to be released to the parties listed above.*

I understand that this authorization will expire on: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Personal Representatives Section (for release of non-substance abuse related information only): If a Personal Representative executes this form, that Representative warrants that he or she has authority to sign this form on the basis of: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client's or Guardian’s name (please print) Client’s or Guardian’s Signature Date

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness name (please print) Witness Signature Date