



**Consent for the Release of Confidential Information**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

I, \_\_\_\_\_ authorize All Day Medical Care to release information to:

- Name of Program/Physician: \_\_\_\_\_
- Name of Institution: \_\_\_\_\_
- Name of Employer: \_\_\_\_\_
- Name of Attorney: \_\_\_\_\_
- Other: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

Person Receiving Information: \_\_\_\_\_ Email Address: \_\_\_\_\_

**For the purpose of:**

- Ongoing collaboration with another provider
- Legal Purposes
- Academic Purposes
- Employment
- Other: \_\_\_\_\_

**I am authorizing the following information to be disclosed:**

- Treatment Engagement including Attendance, Diagnosis and Progress
- Clinical Documentation including Biopsychosocial Assessment and Diagnosis
- Medication Assessment and Prescribed Medications with Diagnosis
- Other: \_\_\_\_\_

I understand that the expiration date of this authorization is \_\_\_\_\_ or 1 year from today's date, whichever is sooner. I understand I may revoke this authorization at any time with a verbal or written request. I understand that if I have authorized the disclosure of health information to someone who is not legally required to it confidential, it may no longer be protected by state or federal confidentiality laws. I understand this consent for the release of alcohol and/or drug abuse information is subject to revocation at any time except to the extent that the information has already been acted in reliance on it. I understand that ADMC abides by 42 CFR Confidentiality regulations/requirements when releasing information related to alcohol and/or drug abuse information.



**ALLDAY MEDICAL CARE CLINIC**  
Serving Children, Adolescents, Adults & Seniors



I understand that a copy of this form is the same as the original.

Client/Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_