



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

Purpose for disclosure: _____

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: _____