RESIDENT RELEASE OF INFORMATION:

I, (print name) ____, SSN ______/_____/________

Authorize: (Organization Name): ____

Contact Person: _____________________________________ Phone: (   ) ________/_____________

Address: ____

City: _______________________________ State: ___________: Zip: __________________________

To release information about me to The Little Tree Project as follows:

YES NO INFORMATION TO BE DISCLOSED

____ ____ Medical (specify)

____

____ ____ Psychiatric/Psychological (specify)

____

____ ____ Legal (specify)

____

____ ____ Education (specify) ____

____ ____ Other (specify)

____

The purpose of requesting this information is to provide Case Management Services. It is understood that the person authorizing release of this information has the right to inspect and copy said information for disclosure and will not be re-disclosed without proper authorization. I understand that records are protected under Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records., (42 CFR Part 2), and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I further understand that this consent is valid for six (6) months from the date of execution and may be revoked at any time except to the extent that action has already been taken.

Resident Name: (printed) _______________________________________ Case #: ________________

Resident Signature: ____ Date: _____/_____/_______

Staff Signature: ____ Date: ____/____ /________