

CLIENT AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, have requested services from Community Servings.
 I understand that in order to provide services, Community Servings may need to release/and or receive information about me to/from:

(Please list the names, phone numbers and addresses of the agencies/persons that we may need to contact)

#	Name of Contact	Name of Agency & Address	Telephone
1.	<i>My Primary Care Physician</i>		
2.	<i>My Case Manager</i>		
3.	<i>Additional contact (if necessary)</i>		
4.	<i>Additional contact (if necessary)</i>		
5.	<i>Additional contact (if necessary)</i>		

I understand and agree that Community Servings may disclose information about my physical, medical, psychological, financial and legal circumstances.

I grant this authorization on the condition that Community Servings will use due care at all times to protect my rights to privacy and confidentiality. I understand that I may revoke this authorization in writing at any time except to the extent that Community Servings has already disclosed information based on this agreement.

Furthermore, unless specifically stated, this release form will be good for one year from the date it is signed.

Signed: _____

Date: _____