



SAN CRISTOBAL ACADEMY

the passage to a new beginning

AUTHORIZATION FOR RELEASE OF INFORMATION

TO: _____

ADDRESS: _____

PHONE: _____ FAX: _____

I, _____, hereby give permission to the clinical staff at the San Cristobal Ranch Academy in connection with my treatment to disclose the following:

- _____ My mental health record in its entirety; or
- _____ My substance abuse record in its entirety; or
- _____ Only the following checked information:
 - _____ Mental Health Evaluation
 - _____ Diagnosis Assessment
 - _____ Substance Abuse Evaluation
 - _____ Treatment Plan
 - _____ Treatment Recommendations
 - _____ Progress Report on my Treatment
 - _____ Attendance Records Only
 - _____ Other _____

Please provide this information as follows:

_____ Verbally _____ Written _____ Other _____

The purpose for such disclosure is:

- _____ To permit continuity of care
- _____ To permit Case Management (including reimbursement determinations and processing benefit claims)
- _____ To enable my employer to make a determination of my employment status
- _____ Other _____

I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. If I do not revoke it, this consent will expire one year after I have terminated treatment with the clinical staff at the San Cristobal Ranch Academy.

Client/Student

Parent/Guardian

Witness

Date