Mission Missouri

The Esther House
509 Ruth St. Sikeston, Mo. 63801
POB 1858   573-481-0505

AUTHORIZATION TO RELEASE, DISCLOSE, AND RECEIVE INFORMATION

I, ____ ________________ ___________________
Name Birthdate Social Security #

Hereby authorize…____
Name of Agency Phone

____
Address

… to release and disclose clinical, medical, psychiatric, drug/alcohol dependency information to Mission Missouri's Esther House. Mission Missouri may also release and disclose information to the above named agency.

This information will be released for the purpose of drug and alcohol rehabilitation and continuing care, and disclosures shall be limited to the following specific types of information:
( ) Narrative account of care history, progress, staff recommendations for continuation of care
( ) Clinical Assessment
( ) Pre-Sentencing/Pre-Hearing Investigative Report
( ) Information for legal purposes or employment
( ) Discharge summary
( ) Psychiatric/Psychological evaluation
( ) Continuation of recovery care plan
( ) Telephone consultation when required
( ) Other (specify) ____

I understand I may revoke this Authorization to Release Information at any time, except to the extent that action has already been taken for the purposes specified above. This Authorization automatically expires when this purpose is fulfilled, and not later than (date) _______________.

All disclosures made as granted by a notice, which states, shall accompany this consent: "This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal Regulation* prohibits you from making further discloser of it without the specified consent of the person to whom it pertains, or as otherwise permitted by such regulation. A general authorization for the release of medical, psychiatric, drug and alcohol-related material is not sufficient for this purpose.
( ) I have received a copy of this Authorization to Release Information.

____
Signature of Applicant Date

____
Signature of Applicant's Parent or Guardian Date

____
Signature and Title of Witness Date