Family Service of the Chautauqua Region, Inc
332 East Fourth Street
Jamestown, NY 14701
Phone: 716-488-1971
Fax: 483-6878
familyservice@familyservicechq.org

Consent to Obtain PHI or Other Confidential Client Information

Client Name: _____ **Date of Birth:** _____
(please print full name)

Authorization for Release of Information from another agency or individual: I authorize the following entity to release my confidential records/information to Family Service of the Chautauqua Region, Inc:

_____
(Please Print Name of agency, address and telephone number)

The purpose of the release is:_____

I authorize the following information to be released to Family Service:

_____

_____

_____

This includes all dates of service unless specified here:_____

This authorization expires when I am discharged from this treatment episode unless otherwise specified here:

_____
(After that date, no more information can be released unless a new Authorization is signed.)

Information obtained from this entity will become part of my medical record and is thereby prohibited from disclosure by Family Service without my consent in accordance with HIPAA privacy laws.

I can cancel this authorization at any time in writing. No information will be shared from that date forward.

I would like a copy of this form. □ **Yes**	
I acknowledge that: I have read this form and understand its contents. I am the patient, or person duly authorized either by the patient or otherwise, to sign this consent and accept its terms.	
Signature of Client	Date
Signature of Parent/Legal Guardian if under the age of 18y/o	Date
Witness (Staff Signature)	Date