CONFIDENTIAL INFORMATION

PERSON SERVED: _____**DOB**: _____**RECORD #**: _____

Abigail Fernandes, LICSW is authorized to **Release to: And/Or (Circle one or both) Request from**:

_____ _____ _____
Person/Organization Telephone # Fax #

_____
Address of Person/Organization

--Person Requesting: _Abigail Fernandes, LICSW_____ __617-285-2334_ ___n/a_____
Person Name Telephone # Fax #

_27 Congress St, Suite 203, Salem, MA 01970_____
Address

The following information and/or documents:

- ❑ Admission Summary
- ❑ Discharge Summary
- ❑ Clinical Treatment
- ❑ Substance Abuse/Treatment (I understand that all related information is protected under Federal and State law, 42CFR , Part 2, and I have the right to refuse lease)

  _____
  Person Served/Parent/Guardian's Signature
- ❑ Psychiatric/Medication Evaluation
- ❑ Psychological Tests
- ❑ Treatment Planning Information
- ❑ Employment Related Information
- ❑ Consults
- ❑ Other_____
- ❑ HIV Related Information (I understand that all related information is protected under Federal Law and that I have the right to refuse release)_____
  Person Served/Parent/Guardian's Signature
- ❑ **Verbal/Telephone Communication**
  RE: _____

For the PURPOSE of:
- ❑ Evaluation/Intake
- ❑ Discharge/Aftercare Planning
- ❑ Treatment Planning
- ❑ Other _____

Legal Matter (specify): _____

This Authorization Expires on: _____(1 Year From Consent)

It is my understanding that this information will be used solely for the purpose described above. I understand that I may revoke my permission at any time except after the information has already been released, and to the extent that action has been taken in reliance on it.

Person Served/Parent/Guardian Signature: _____Date:_____

Witness: _____Date:_____

REFUSAL:
I do **not** authorize Abigail Reynolds, LICSW to release information at this time.
Person Served/Parent/Guardian Signature:_____ Date:_____