Associates at Hope Harbor
RELEASE/OBTAIN OF INFORMATION FORM

I, _____ DOB_____

hereby authorize Associates at Hope Harbor to ☐ **release** and/or ☐ **obtain** information pertaining to my evaluation and/or treatment to:

1. Person: _____

   Facility: _____

   Phone: _____Fax: _____

   Email: _____

2. Person: _____

   Facility: _____

   Phone: _____Fax: _____

   Email: _____

Information to be disclosed for the purpose(s) of:

☐ Evaluation	☐ Monthly Reports	☐ Police Report
☐ Treatment Plan	☐ Discharge Summary	☐ Treatment Summary
☐ U.A.	☐ Collaborating Reports	☐Other_____

I understand that authorization shall remain valid for one year from the date of my signature below.

I have been informed that I may revoke this authorization by written or oral communication to Associates at Hope Harbor.

I certify that this form has been fully explained to me and that I understand its contents.

_____ _____
Client Signature (Client's Parent/Guardian if under 18) Date

_____ _____
Witness Signature Date