

**Consent for the Release of Confidential Information
To Other Treatment Facilities, Family Member, or Others**

I, _____ authorize Sees-The-Day, Inc. to disclose to _____
Resident's Name *Agency/Person's Name*

the following information:

- Psycho-Social
- Treatment Plan
- Attendance, progress, cooperatives in treatment
- Discharge summary/aftercare plan
- Other: _____

For the purpose of:

- Determination of treatment needs
- Continuity of care
- Coordination of services
- Compliance with probation/parole regulations
- Obtaining assessment/evaluation information
- Other: _____

I understand that my records are protected under the Federal Confidentiality regulations and cannot be disclosed without my written consent, unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the event that this consent automatically expires three (3) months following discharge from treatment.

Specification of the date, event, or condition upon which this consent expires: _____

Resident's Signature

Date

Witness Signature

Date

Guardian Signature

Date

I have been offered and received a copy of this consent.

I have declined a copy of this consent.

Resident's Signature