**RELEASE OF INFORMATION**

I, ( **<Patient’s Name> \_\_\_\_\_\_\_\_\_\_\_\_\_**) hereby authorize any physician, counselor, medical treatment facility or substance abuse treatment counselor, facility or program to release any and all information and records to **Court Appointed Special Advocates (CASA) and (CASA Guardian ad Litem)** regarding the care, treatment, and services provided to

( **<Patient’s Name> \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**)

* **Preferred** delivery method: **<GAL’s email>**

**or**

* If information is to be mailed, please mark "Confidential" and mail to:

 CASA of Franklin County

 373 S. High St, 15th Floor

 Columbus, OH 43215

 **or**

* Fax to: 614-525-5070

This release shall not be interpreted to supersede any state or federal law restricting release of medical or substance abuse information.

I understand that I have been given an opportunity to discuss this “Release of information” (hereinafter “Release”) and that I have received a copy of this form. I also understand that I may revoke this “Release” at any time by stating so in writing with the date and my signature. I also understand that if I revoke this “Release”, the revocation of this “Release” will not apply to any information which has been shared between the time I signed this “Release” and the time I revoke this “Release” in writing.

A photocopy of this “Release” shall be accepted as if it were the original.

This authorization expires one (1) year from the signed date unless otherwise revoked prior to that date.

Full Name:

Date of Birth:

Social Security Number:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Witness Signature Date