Stable Living
Your Path to Personal Growth & Healthy Relationships

RELEASE OF CONFIDENTIAL INFORMATION

CLIENT: _____ DATE: _____ DOB: _____

Address: _____

City/State/Zip: _____

I HEREBY AUTHORIZE STABLE LIVING LLC THERAPIST:

Therapist's Name: _____

AND:

Name: _____

Oranization: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

TO EXCHANGE OF THE FOLLOWING INFORMATION: (Check all that apply)

- ❍ Phone Consultation
- ❍ Social History
- ❍ Diagnosis
- ❍ Progress Notes
- ❍ Treatment Plan
- ❍ Discharge Summary
- ❍ Medical History
- ❍ Chemical Dependency Evaluation
- ❍ Psychological Tests
- ❍ Other _____

THIS INFORMATION IS NEEDED FOR THE FOLLOWING PURPOSE:

1) To effect a continuum of care for the client's recovery.

2) Other _____

I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION, IN WRITING, AT ANY TIME AND THAT UPON FULFILLMENT OF THE ABOVE STATED PURPOSE, THIS AUTHORIZATION WILL EXPIRE. IN ANY CASE, THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE ONE YEAR FROM THE DATE SIGNED.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____

Stable/Office Location: 680 Game Farm Road, Minnetrista, MN 55359 • Phone 952.240.1621 • Fax 763.479.4050