**CONFIDENTIAL**

**Transcultural Care**
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## RELEASE OF INFORMATION

Patient's name: _____ Date of birth: _____

Information may be disclosed to or obtained from:

_____

Specifically, I authorize the exchange of the following confidential information by my **initials**:

_____ Mental health treatment information

_____ Drug/alcohol treatment information

_____ History/physical exam, and laboratory results

_____ Other _____

I understand that any of the above requested information may include results of substance abuse and/or diagnosis and treatment of mental health disorders.

I understand that I can revoke this authorization at any time by providing a written letter of my intent to revoke but that revoking it will not affect disclosures made before the revocation letter is received. This consent shall expire in one (1) year following the end of treatment.

Patient's printed name _____

Patient signature _____ Date _____