Clear Horizons Clinical Services

853 West Center St.
Orem, Utah 84057
(801) 358-4463

Request/Authorization to Release Confidential Records and Information

I hereby authorize Person or facility: DCFS
Address: 150 East Center Street, Ste. 5100, Provo, UT 84601
Phone: (801) 374-7005
To release information from records about: _____
Date of birth: _____

For the following purpose(s):

- ☒ Further mental health evaluation, treatment, or care
- ☐ Research
- ☐ Rehabilitation program development or services
- ☒ Treatment planning
- ☒ Other: Verbal and/or Written _____

These records concern the dates between _____ and _____. (Please use mm/dd/yyyy format)

In the boxes below, the information to be disclosed is marked by an X or check mark. page numbers are indicated when appropriate. Written dates indicate when those records wre mailed to the requester.

- ☒ Intake and discharge summaries
- ☐ Medical history and evaluation(s)
- ☒ Mental Health Evaluation
- ☒ Developmental and/or social history
- ☐ Educational records
- ☒ Progress notes, and treatment or closing summary
- ☒ Other: Verbal and/or Written _____

Indicate what request is being made:

- ☐ Please forward the records to the address in the letterhead at the top of this form.
- ☐ Please forward the records to the address written above.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the likely consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 1 year, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 1 year from the date on which it is signed, or upon fulfillment of the purposes stated above.

Signature of Client	Printed Name	Date

Signature of Parent/Guardian	Printed name	Relationship	Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent.

Signature of Witness	Printed Name	Date

❑ Copy for patient or parent/guardian ❑ Copy for source of records ❑ Copy for recipient of records