THE CHILD ADVOCACY CENTER (CAC) OF SANILAC COUNTY
SEXUAL ASSAULT AND DOMESTIC VIOLENCE COALITION WITH SANE/SART SERVICES OF SANILAC COUNTY

GENERAL RELEASE AUTHORIZATION

CLIENT NAME: (Please print)____ Date of Birth: ____________
PARENTS NAME: ____ authorize **Sanilac County CAC** and/or its designee:
____**Therapist** ____**Reception** ____**Medical Records Personnel** ____**Billing Staff** ____**Psychiatrist**
_**X**__**MDT** (Multi-Disciplinary Team) to release information to the Sanilac County CAC.

The information contained in my medical record including information about Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS) and AIDS Related Complex (ARC); and including substance abuse (alcohol and drug) treatment records protected under the regulations in Code 42 of Federal Regulations, Part 2; psychologist or psychiatrist, if any, to the individuals or organizations listed below:

To release/obtain/exchange information, please indicate the specific required information:

____Past & Present Status ____Findings from Psycho-social, Psychological, Psychiatric, and/or Chemical Dependency Evaluations ____Diagnosis & Attendance ____Treatment Recommendations ____General Evaluation of Progress in Treatment ____Copies of any/all of the Medical Records _**X**__**Info from Forensic Interview and/or MDT info**

To the following individual(s) and organizations: (example: private therapist, medical, school personnel)
Name:____
Address: ___________________________ City: ______________________ State: _________ Zip Code:____________

*****Name of additional parent/caregiver that can legally consent for child and/or discuss case information***:**

Name: ____ **Relation:** ________________________________

For the Purpose of: Case Review / Case Tracking / MDT / Investigations / Referrals

I hereby release **Sanilac County CA**C and its staff from all legal responsibility or liability that may arise from the release of the above information and/or these records. I understand that I have the right to receive a copy of this authorization after it is signed and witnessed. I also understand that I have a right to inspect and/or copy my Private Healthcare Information, which is to be disclosed. I understand **Sanilac County CAC** will not condition treatment on whether I sign this authorization. I further understand that I may restrict the disclosure of my Private Healthcare Information as noted above.

The information released with this authorization is confidential. Further, disclosure of this information is prohibited unless otherwise permitted by State and Federal laws (PA 258 of 1974; PA 368 of 1978; 42 CFR Part 2; PA 488 of 1988; 45 CFR parts 160 & 164)

This release consent will expire **1 year** from the date of signature. If no date is selected, the release consent will expire 90 days after the date signed, or sooner following my discharge from services. I understand that I have the right to withdraw this authorization at any time except, to the extent that action has been taken in reliance upon my authorization. Such a withdrawal must be in writing with a copy sent to **Sanilac County CAC**.

Signature: ____ Date:___________________

If signed by a person other than the client, please state relationship and authority to do so:
____Parent of Minor Child ____Personal Representative of Deceased ____Power of Attorney ____Legal Guardian
Witness Signature: ____ Date: __________________

Copy requested by Client: ____Yes ____No ____Refused