



PERMISSION TO RELEASE INFORMATION

I (we) _____, SSN _____,

DOB _____, hereby authorize and request Emilio A. Yonta, PhD, LCSW, of CORE

Counseling Service, Inc. to release confidential professional information, including personal,

psychological, psychiatric, and medical records and opinions, resulting from my contacts with

them/him/her, to _____

(address) _____ (phone) _____.

Specific information requested is as follows:

_____ Alcohol or Drug Treatment

_____ Billing Information

_____ HIV Status

_____ Case Management, for continued care

Other _____

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFT Prt 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires: _____ after a period of 90 days from the date of my signature below, or: _____ after length of treatment.

In consideration of this consent, I hereby release the above parties from any and all liability arising there from

Signature: _____
Patient/Parent/Legal Guardian

Date: _____

Print Name _____

Witness: _____

Recipient: Your prompt attention to this request will be greatly appreciated.
(Photocopies or facsimiles of this form are acceptable) 052006