INSTITUTE FOR CHILDREN'S AID
A Voice of HOPE for Children Worldwide

Release of Confidential Information

Completion of this form authorizes release of information described in the section below called "Specific Description of Record Authorized for Release." The person whose records are to be released may have a right to inspect and, upon paying any applicable fees, obtain a copy of the disclosed records. Except for medication/somatic treatment records, a director/designee of a treatment facility for mental illness, developmental disability, alcohol or drug abuse may deny that right during treatment in some circumstances.

Name of person whose records will be released: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____

Please complete the chart below with all Agencies or Parties who you wish to authorize to share information to or with ICA

Agency Information: Name, Contact Person, Address, Phone	**ICA may Release Information TO this Agency**	**This Agency may Release Information TO ICA**
Name: Institute for Children's Aid Contact Person: _____Address: 41745 Rider Way | Temecula, CA | 92590 Phone: 951.695.3336	**N/A**	**N/A**
Name: Contact Person: Address: Phone:	☐	☐
Name: Contact Person: Address: Phone:	☐	☐
Name: Contact Person: Address: Phone:	☐	☐

Specific Description of Records Authorized to be Released (include dates of records if applicable):

Purpose or Need for Release of Information (Be Specific):

Understandings:

♦ This authorization is voluntary. Refusal to sign will not affect treatment, payment, enrollment or benefit eligibility except for:

_____No Exceptions _____Exceptions:

♦ The information that I authorize to be released may be redisclosed by the recipient of the records only if allowed by law. If information is redisclosed, the recipient of the disclosed information may be controlled by different laws.

♦I may revoke this information, in writing, at any time for information already released as a result of this authorization. The written revocation must be given the agency/organization I authorized to release the information.

♦Unless revoked, this authorization will remain in effect until the authorization time listed below.

Choose One:

_____Authorization expires as of:_____(Date)

_____Authorization expires_____month(s) from the date I signed this authorization.

_____Authorization expires after the following action takes place: _____

As evidenced by my signature, I hereby authorize disclosure of records to the person(s) or agency(s) specified above.

Signature of Person whose records will be released:	Date:
Printed Name of LEGAL Guardian:	Title or Relationship:
Signature:	Date: