RELEASE OF INFORMATION

MASON ASSOCIATES LLC

I, _____, _____hereby authorize the staff of
Full Legal Name Date of Birth

Mason Associates LLC to release information contained in my client records to the following individual(s) and/or organization(s), and only under the conditions below.

1. Name of person(s), organization(s), and address to whom disclosure is to be made:

   _____

   _____

   _____

2. Information to be disclosed: *check all that apply*

	Diagnosis		Drug/Alcohol History
	Entire Record		Attendance
	Mental Status Exam		Prognosis
	Discharge Summary		Treatment Summary
	Progress		Other:

3. Purpose of Disclosure: *check all that apply*

	Provision of Mental Health Services		Billing Purposes
	P.O. / Attorney / Court / Judge		Aftercare Planning
	Family Involvement		Continuity of Treatment

4. Without expressed revocation, this consent expires one(1) year after the date signed.

5. This consent is subject to revocation at any time except in those circumstances in which the program has taken certain actions on the understanding that the consent will continue unrevoked until the purpose of which the consent was given shall have been accomplished. However, any consent given under Subpart C, Federal Register, Volume 40, Number 127, July 1, 1975, Shall have a duration no longer than that reasonably necessary to effectuate the purpose for which it is given.

_____ _____
Client (Parent/Guardian) Signature Date

_____
Printed Full Legal Name

_____ _____
Staff Signature Date