Authorization To Release Information

Name of Participant: _____

I hereby request and authorize:

Sanctuary First Foundation
732 Broadway, Suite 201,
Tacoma, WA 98402
Phone: (661) 699-0669

To disclose to or obtain information from:

_____

Name of person or agency holding information

_____

Address of person or agency holding information

The following type(s) of information from my records (and any specific portion thereof):

_____ History and Physical

_____ Alcohol and Drug Abuse Treatment Records

_____ Laboratory Reports

_____ Psychological Reports

_____ Other

for the purpose of _____

All information I hereby authorize to be obtain from this agency will be held strictly confidential and cannot be released by the recipient without my written consent. I understand that this authorization will remain in effect for:

____ Ninety (90) days unless I specify an earlier expiration date here: _____

____ One (1) year

____ The period necessary to complete all transactions on account related to services provided to me.

I understand that unless otherwise limited by state or federal regulation, and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

Date

Participant Signature

Witness/Title Signature

Sanctuary First Foundation House Lead/Staff Signature