HOPE COUNCIL
OFFERING HOPE | HELPING TO HEAL

SUPERVISED VISITATION PROGRAM
AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ D.O.B.: _____

I, _____, hereby request and authorize the

Supervised Visitation Program of the Hope Council on Alcohol & Other Drug Abuse to

_X_ Disclose information and records to: the Guardian Ad Litem and both parent's attorneys *(include names and addresses if possible)*

_____

_X_ Receive information and records from: the Guardian Ad Litem and both parent's attorneys *(include names and addresses if possible)*

_____

__ Receive information and records from: other *(specify, including name and address)* _____

__ Disclose information and records to: other *(specify, including name and address)* _____

(I understand that both parents must agree for records to be released in order for this to occur.)

The information to be provided covers the time period of: _____

This authorization will expire in one (1) year, unless an earlier date is specified as follows:_____

Your Rights With Respect To This Document

You have the right to receive a copy of this authorization. You have the right to refuse to sign this authorization. You understand that this authorization is voluntary and that you may refuse to sign it. Unless allowed by law, your refusal to sign this authorization will not affect your ability to obtain services. You have the right to withdraw this authorization at any time. You must submit written notification of your desire to cancel this authorization. You should be aware that your cancellation will not be in effect until it is received by the Hope Council and will not be effective regarding the uses and disclosures made prior to the cancellation.

_____

(Client Signature & Date)