



FUTURES COMMUNITY SUPPORT SERVICES INC.  
23 MAIN STREET, TOWANDA, PA 18848 • TELEPHONE (570) 265-3800 • FAX (570) 265-8271

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## AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to

release or obtain *(circle one)*

confidential information of the person named above to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

For the purpose of: \_\_\_\_\_

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This request and authorization applies to:

Healthcare information relating to the following treatment, condition, or dates: \_\_\_\_\_  
\_\_\_\_\_

All healthcare information

Other: \_\_\_\_\_

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Yes  No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_

Witness: \_\_\_\_\_ Date Signed: \_\_\_\_\_

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.