Alternative Health Consultants

A California Corporation

Authorization to Release – Exchange Confidential Information

(Waiver of Confidentiality)

I, (Print Name of Client) _____ hereby authorize ***Alternative Health Consultants*** to release – exchange confidential information regarding my case with the following entities: Please initial each. If you have a question – please ask so that we may answer your questions fully.

- ☐ *My Victim, Current Partner, and Past Partners*
- ☐ *Victim Advocacy or Support Agencies / Shelter for Battered Women*
- ☐ *Prior Batterer's Intervention Programs and Concurrent & Past Treatment Programs*
- ☐ *All relevant legal entities such as criminal, juvenile, and civil courts*
- ☐ *Public Defender's Office and my Attorney*
- ☐ *Police, Parole, & Probation Departments*
- ☐ *District Attorney's Office*
- ☐ *Department of Family & Children Services & Child Protective Services*
- ☐ *Office of Pre-Trial Services*
- ☐ *Any other entity that the Court may specifically direct.*

This Authorization permits the release – exchange of the following information:
Any and all information necessary as determined by court, probation, my referring party, and AHC as per my treatment program / case plan.

I authorize the release – exchange of information described above for the following purposes: *Facilitation of Treatment, Clarifying Referral Information, Consultations, Progress Reports, Updates, Testifying as per a subpoena, etc.*

The recipient may use the information described above for the following purposes: *General facilitation of my case, and Victim Safety Issues, etc.*

I understand that I have the right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing. I further understand that if Alternative Health Consultants requests that I sign another more comprehensive or specific release I will comply. Failure to do so may put me at risk of dismissal from the program and referred back to court, probation, and / or any other referring parties.

This authorization shall remain valid while client is in treatment, and up to 1 year thereafter. A copy is as valid as the original. I authorize that this form may be faxed if necessary. I have read this release and understand the specific agencies that this release recognizes.

By: _____ Date: _____
(Client or Client's Representative)

Witnessed: _____ Date: _____
(Agency Representative)

If signed by other than Client – please indicate the relationship between Client and his / her Representative. _____

Offices located at:

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