



Authorization To Release Information

Name of Participant: _____

I hereby request and authorize:

Fostering Excellence In Someone Foundation
301 Union St #21867, SMB#57613
Seattle, WA 98111
Phone: (630) 360-5934

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 obtained 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

FEIS Foundations House Leader/Staff Signature