

**Family Therapy of Albuquerque**

8600 Academy Rd. N.E.  
Albuquerque, NM 87111  
(505) 821-3628

**CONSENT FOR THE RELEASE AND EXCHANGE OF  
CONFIDENTIAL INFORMATION**

**Name** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_  
(name of person requesting the release)

I request and authorize \_\_\_\_\_ to release to  
(person making the disclosure)

and exchange with \_\_\_\_\_  
\_\_\_\_\_  
(name, address, phone number of primary medical doctor)

the following:

\_\_\_\_\_  
\_\_\_\_\_  
(nature of the information to be released and exchanged)

Purpose of the request: \_\_\_\_\_

Please initial if you are willing to have personal information released regarding:  
HIV Status \_\_\_\_\_ Substance Abuse \_\_\_\_\_

This authorization shall become effective \_\_\_\_\_. This release of information is subject to revocation in writing by the undersigned at any time. This authorization will expire, if not revoked by the undersigned, on: \_\_\_\_\_ (one year from effective date).

I understand that this information will be used only for the purposes noted above. A photocopy or fax copy of this authorization, which contains my signature, shall be considered as effective and valid as the original.

\_\_\_\_\_  
(signature of client) Date \_\_\_\_\_

\_\_\_\_\_  
(signature of parent, guardian, conservator, or second/conjoint client as applicable) Date \_\_\_\_\_