CONFIDENTIALITY RELEASE

Each adult client in the household, who is present, must read and initial each statement.

_____ _____I authorize Hope House located at 178 Brackett's Way, Blairsville, Georgia, to Release confidential information including personal, psychological, psychiatric, drug/alcohol, criminal, medical records, and opinions resulting from my interview with a Hope House intake worker to other Union County agencies, surrounding agencies and churches involved in our ministry. Disclosure of my information shall be for the express purpose to obtain assistance with my situation. All parties will maintain the strictest of confidentiality in dealing with my information.

_____ _____ I understand that any cancellation or modification of this authorization must be in writing. I have a right to receive a copy of this authorization upon my request. A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____ This authorization shall remain in effect and valid for one (1) year.

_____ _____I release all parties stated here within from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise appropriate safeguards while using this information.

_____ _____ I further certify by my signature that the information I provide to Hope House is **true and correct** to the best of my ability. Should the information I supply Hope House be determined to be false and an attempt to defraud Hope House, I understand I will become **immediately ineligible** for any assistance for **anyone in my household** for **12 months**.

CLIENT #1	***CLIENT #2 (if present)***
_____	_____
Print	Print
_____	_____
Signature	Signature
_____	_____
Date	Date

Rev 2/2019