RELEASE OF INFORMATION
HHFH Residential Program
HHFH Drop-In Program
HHFH Peer Navigation Program

As part of my application process for any of the programs at His House for Her, Inc. I, _____, hereby authorize any of the entities specified below to release without liability, information regarding my physical, mental health, and psychiatric medical history, substance use history, history of treatment for substance use, employment, income, and/or criminal background.

I understand that this authorization can only be used to obtain information about me that is pertinent to my eligibility for the programs at His House for Her, Inc. Pertinent information includes my physical and mental health medical history, substance use history, history of treatment for substance use, and my ability to pay required program fees.

The following groups or individuals will be contacted as deemed necessary. The groups or individuals that may be contacted include, but are not limited to:

- Any and all Physicians
- Any and all Treatment and Recovery Centers
- Any and all Treatment Providers, Clinicians and Therapists
- Past/Present Employers
- Background Check Providers
- Attorney, Probation and/or Parole Office and Department of Corrections
- Department of Children and Families, Guardian-ad- Litem Program and any case management agencies
- Friends, Personal Contacts, Family Members
- Any and all social service agencies pertinent to my treatment and recovery

CONDITIONS:

I, _____, agree that a photocopy of this authorization may be used for the purposes stated above. The original of this authorization in on file and will stay in effect for a year from the date signed. I understand that I have a right to review this file and correct any information that I can prove is incorrect.

ACKNOWLEDGEMENT:

My signature below signifies that I have read and understand the terms and conditions set forth in this Release of Information.

_____ _____

Signature of Program Participant/Resident Date