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AUTHORIZATION & REQUEST FOR RELEASE OF INFORMATION

Client's Printed Name: _____ **Date of Birth:** _____

(Please check all that apply)

☐ To exchange information with:
☐ To disclose information to:
☐ To obtain information from:

Name: _____
Address: _____
City: _____ St: _____ Zip: _____
Phone: _____ Fax: _____
Email: _____

Information to be released or exchanged include (check all that apply):

☐ Discharge and Summary
☐ Summary report of services received
☐ Therapy notes including Treatment Plan (last 6 months)
☐ Assessments/Evaluations
☐ Other: _____

The authorized purpose(s) for this release are:

☐ Diagnosis and Treatment
☐ Coordination of Care
☐ Personal Use
☐ Consultation and/or verbal communication between the above named parties
☐ Other: _____

Expiration date: _____(one year from date signed if not otherwise specified - effective for one year maximum).

I understand that my treatment will not be conditioned upon signing this authorization and that I have the right to revoke the authorization, except to the extent action has been taken or it has been relied on, by putting my revocation in writing and delivering it to the clinician identified above.

I issue this authorization with knowledge of the contents of the material and communication and understanding of the consequences, and do so voluntarily and free from duress or undue influence.

I agree to pay a reasonable fee, if any, for the preparation of the materials and hereby hold harmless the above-named clinician from any liability relevant to the release of confidential information or privileged communication.

_____ _____

Client/Guardian Signature Date Client/Guardian Signature Date