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Authorization for Release of Information

1. Client's Name: _____ DOB: _____

2. Information to be released :

Summary of treatment to date

Other: _____

3. Purpose of Disclosure:

Coordination of Care

Other: _____

4. Persons authorized to make Disclosure:

5. Person authorized to receive Disclosure:

6. Method of Disclosure

Written : _____

Verbal: _____

Electronic: _____

7. Today's date: _____ Authorization to expire on: _____

I understand that my health information is protected by law. I authorize the release of my confidential health information as indicated above. I understand that my consent is voluntary and I can revoke this permission at any time, except to the extent that it has already been shared based on this authorization. Should I choose to revoke this authorization I will state this in writing.

Signature of Client

Date:

Signature of Guardian/ Personal Representative

Date:

Signature of Clinician

Date: