AUTHORIZATION FOR RELEASE OF INFORMATION

1.Client's Name _____

2. Information to be released:

- ☐ Summary of treatment to date
- ☐ Report
- ☐ Other: _____

3.Purpose of Disclosure:

- ☐ Coordination of Car
- ☐ 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 ha 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