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 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 had already been shared based on this authorization. Should I choose to revoke this authorization, I will state this in writing.

Signature of Client or Legal Guardian	***DOB***	***Date***
______________________________	________________	________________
Sign Full Name	*MM-DD-YYYY*	*MM-DD-YYYY*

SIgnature of Therapist	***Date***
____	________________