Authorization for the Release of Information

Client Name: _____ Birth Date: _____
Address: _____
SSN: _____ Phone: _____

I hereby authorize _____(Therapist) to:

_____ Discuss With _____ Send To _____ Receive Information From

_____
(Name and Address)

For the specific purpose of:
_____
_____
_____

Information to be released:

____ Medical Evaluation/History/Physical
____ Psychiatric Evaluation/History
____ Social History
____ Psychological
____ Insurance Records
____ Discharge Summary
____ Educational Records
____ Court Records
____ Progress Notes
____ Physicians Orders/Notes
____ Treatment Plans
____ Laboratory Test Results
____ Treatment History
____ Other _____
____ Other _____
____ Other _____

This authorization will remain in effect for one year following the date of signature. I understand that I have the right to revoke this authorization at any time, but if I do choose to revoke I must do so in writing. I understand that the revocation will not apply to: information that has already been released in response to this authorization or my insurance company (if applicable) when law provides my insurer with right to contest a claim under my policy. I understand that authorizing disclosure of this health information is voluntary and I can refuse to sign. I need not sign in order to assure treatment. I understand that I may inspect/ copy information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and information may not be protected by federal confidentiality rules.

_____ _____
Signature of Client Date

_____ _____
Witness Date

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