Authorization for Release of Information

1. Client's Name: _____

   DOB: _____

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:

   _____
   _____

Person authorized to receive Disclosure:

_____
___

5. Method of Disclosure
   Written: _____

   Verbal:
   _____

   Today's date: _____Authorization to expire on:
   _____

I understand that law protects my health information. 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.

Printed name of Client: _____Date:
_____

Printed name of Guardian: _____Date:
_____

Signature of Guardian if applicable:

_____Date: _____

Signature of Client or Clients if applicable:

_____ Date:

_____ _____

Signature of Clinician: _____ Date: _____