Authorization for Release of Information

Client's Name: _____

DOB: _____

Information to be released :

[ ] Summary of treatment to date
[ ] Report
[ ] Other: _____

Purpose of Disclosure

[ ] Coordination of Care
[ ] Other:_____

Persons authorized to make Disclosure:

Name: _____

Person authorized to receive Disclosure:

Name: _____

Address: _____

Phone: _____Fax: _____

Method of Disclosure

[ ] Written
[ ] Verbal
[ ] Electronic/E-Mail
[ ] Fax

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 Patient: _____ Date: _____

Signature of Personal Representative: _____