Authorization for Release of Information

CONTACT 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:
_____

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 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:_____