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AUTHORIZATION TO RELEASE INFORMATION

Name: ____ DOB: _________________

I hereby authorize ____________________ and ____

to exchange information regarding my treatment as specified in this form.

____ Diagnosis ____ Treatment summary ____ Consultation

____ Treatment update ____ Psychosocial history ____ Psychological Testing

____ Account/Payment/Insurance/Schedule Appts ____ Other (specify: ____________)

I authorize the method of transmission of information: ☐ Verbal ☐ Electronic ☐ Written

I understand that this information for release is subject to revocation at any time and that revocation of authorization must be done in writing. I understand that the revocation will not apply to information that has already been realized in response to this authorization.

I understand that the disclosure of information may contain alcohol/drug treatment information or psychiatric/psychological information. I understand that the disclosure of information may no longer be protected by state or federal confidentiality laws once information is related to a third party who is not legally required to keep information confidential. I understand that all parties are prohibited from re-disclosure of this information except with the specific written consent of myself or my representative. A general authorization for release of medical or other information is sufficient for this purpose.

I understand that refusal to sign this authorization will not affect the client's ability for treatment, payment, enrollment in a health plan or eligibility for benefits.

This consent, if not withdrawn, will expire on ____________ or 180 days from the date on which it is signed.

____ ________________________________

Patient/Guardian Signature Witness

____ ______________________

Patient Name (print) Date