Authorization for Release of Information

CLIENT NAME:_____ DOB:_____

INFORMATION TO BE RELEASED:
☐SUMMARY OF TREATMENT
☐DATES OF TREATMENT
☐OTHER:

_____

PURPOSE OF DISCLOSURE:
☐COORDINATION OF CARE
☐OTHER:_____

PERSON (S) AUTHORIZED TO MAKE
DISCLOSURE:_____

PERSON AUTHORIZED TO RECEIVE DISCLOSURE:

METHOD OF DISCLOSURE: (CHECK ALL THAT APPLY)
☐WRITTEN
☐VERBAL
☐ELECTRONIC

TODAYS 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 WITNESS:_____DATE: _____