

Authorization for Release of Information

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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. Persons 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 _____ Date _____