Release of Information

Authorization for the use and disclosure of Protected Health Information (PHI) is only for the person or agency on this form.

Name: DOB: SS#

I, , authorize

whose office is located at

to release/exchange by phone, fax, email or mail my PHI with:

Reason for Disclosure:

The PHI to be disclosed includes the following:

- Assessment Information
- Diagnosis
- Treatment Planning Notes
- Progress & Treatment Notes
- Medication
- Recommendations
- Results of Psychological Testing
- Psychiatric Evaluation
- Reasons for Termination
- Other

For the purpose of:

- Collaboration
- Insurance
- Continued Care/Treatment
- Legal
- Other

Dates of records to be release:

Release will expire:

- End of 60 days
- Termination of treatment
- As of

By signing below, I acknowledge that the above information about me may be released, discussed, or disclosed. I also understand that I may revoke this authorization at any time and must do so in writing and present this written revocation to my therapist.

Client Signature Date

Parent/Guardian/Legal Representative Signature Date

Therapist/Provider Signature Date