

Authorization for Release of Information

Client Name

Date of Birth

I authorize the following provider: _____

To exchange information by:

- ☐ Sending
- ☐ Receiving

The following types of information:

Please select authorization of general information or disclosure of specific kinds of records.

- ☐ Communication/disclosure of general information between healthcare providers regarding client's case for the purposes of coordinating healthcare services and providing the client with the best care.
- ☐ Assessment
- ☐ Diagnosis
- ☐ Treatment Plan
- ☐ Treatment summary
- ☐ Medical history & physical/diagnosis/treatment
- ☐ Educational/IEP/assessment
- ☐ Progress/case notes
- ☐ Psychological testing report
- ☐ Termination/discharge info
- ☐ Entire Client File
- ☐ Financial/health insurance info
- ☐ Other: _____

To/from the following party:

Other Party Name

Address

Phone

Email

FAX

This authorization expires in one (1) year unless a shorter length of time is entered here:

I understand my health information is protected by state and federal guidelines and cannot be released without my consent unless allowed by law. Only the information indicated above will be released exclusively between the entities listed above. I understand I can withdraw or modify this authorization at any time. My signature means I have read and understand this form.

I am:

- ☐ The client
- ☐ Parent/legal guardian
- ☐ Representative
- ☐ Other

Signature

Date