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 ____