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AUTHORIZATION FOR RELEASE OF INFORMATION

This form, when completed and signed by you, authorizes the release of protected information from your clinical record to the person you designate.

Client's Name:_____ **DOB:**_____

I, _____*(Printed Client or Legal Representative Name)* hereby authorize

_____*(Provider Name)* to ***release / receive / exchange*** (circle one) the

following:

Initial all that Apply

_____ Any and All Information Necessary

_____ Diagnosis _____ Treatment Plan _____ Prognosis

_____ Progress to Date _____ Clinical Test Results _____ Dates of Treatment

_____ Patient Records _____ Summary of Treatment

_____ Other _____

This information should only be ***released to / received from / exchanged with*** (circle one):

(Provide name or function and address of person to whom the information is to be released.)

_____*(Name or Function)*

_____*(Address)*

_____*(Phone/Fax Number)*

I am requesting my provider to release this information for the following reasons, and subject to the following limitations: ("At the request of the individual" is all that is required from the patient if he/she does not desire to state a specific purpose.)_____

_____

This authorization shall remain in effect until (date):_____/_____/_____or upon happening

of the following event: _____

Authorization and Signature: I understand that this authorization is **voluntary** and I have the right to revoke or modify this authorization, in writing, at any time by sending *written* notification of that revocation or modification to my provider's office address. However, my revocation or modification will not be effective (a) until my provider receives it; (b) to the extent that information has already been shared based on this authorization; or (c) to the extent that this authorization was obtained as a condition of obtaining insurance coverage.

I understand that my provider generally may not condition treatment upon my signing an authorization unless: 1) my treatment is related to research and the authorization is to allow the use or disclosure of Protected Health Information for that research; or 2) the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient of my information and may no longer by protected by the HIPAA Privacy Rule.

I further understand that I am entitled to receive a copy of this authorization.

A copy of this authorization shall be considered as valid as the original.

_____ _____

Signature of Patient or Personal Representative *Date*

_____

Relationship to Patient, if Other than Self, and Description of Authority to Act for the Patient

_____ _____

Signature of Witness *Date*