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Authorization for Release of Information

Client's Name: _____ DOB: _____

Information to be released:
□ Summary of treatment to date
□ Report
□ Other: _____

Purpose of disclosure:
□ Coordination of care
□ Other: _____

Person(s) authorized to make disclosure: _____

Person(s) authorized to receive disclosure: _____

Method of disclosure
□ Written: _____
□ Verbal: _____
□ Electronic: _____

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 information has already been shared based on this authorization. Should I choose to revoke this authorization, I will state my request in writing.

Signature of Client: _____ Date:_____

Signature of Personal Representative: _____