

Authorization for Release of Information

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. Person authorized to receive _____

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: _____