

## 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 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: \_\_\_\_\_