Authorization for Release of Information

Regarding the protected health information of: _____
Patient Name

I authorize _____ and/or administrative staff to
Provider Name

( ) Obtain and Release ( ) Obtain only ( ) Release only the information below to/from:

(Name and contact information of person or organization)

_____

_____

_____

( ) Communication/Consultation ( ) Summary Reports ( ) Progress Notes ( ) Entire Record
( ) Academic & Intelligence Testing Reports ( ) Psychological Testing Results and Reports
( ) Lab Reports and Medical Record ( ) Other (specify) _____

The above information will be used for the following purposes:

( ) Planning Appropriate Treatment or Program ( ) Determining Eligibility for Benefits or Program
( ) Continuing Appropriate Treatment or Program ( ) Case Review ( ) Updating Files
( ) Other (specify) _____

I understand that I may revoke this consent at any time by providing written notice which will be effective for all future protections of privacy. I understand that if I gave my provider previous permission to disclose information to an individual or organization that the revocation will be effective on the date signed above. I have been informed what information will be given, its purpose, and who will receive the information. I hereby release the above parties from all liability arising there from.

Signature of Patient _____ Date_____

Signature of Parent/Guardian _____ Date_____

Name of Child if under 18 _____

Relationship to child ( ) Parent ( ) Legal Guardian _____