



Authorization Release/Receive Form

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 client (12 yrs+) _____ Date: _____
Signature of Witness: _____ Date: _____