

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