AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH & CONFIDENTIAL INFORMATION

Client's Name ______________________________ Birth Date ______________

I, ______________________________ and/or ______________________________
Name of Client — Name of Parent/Guardian/Conservator

hereby authorize ______________________________ to:
(Therapist/Evaluator)

(Circle all that apply) Release Verbally Exchange Receive

the following protected health information or confidential information:

- ☐ Diagnosis
- ☐ Intake Summary
- ☐ Closing Summary
- ☐ Progress in Treatment
- ☐ Alcohol/Drug Information
- ☐ Psychological Evaluation
- ☐ Psychiatric Evaluation
- ☐ Medical Information
- ☐ Verification of Attendance/Treatment
- ☐ Other ______________

to: *(Name of Person/Agency/Organization)* ______________________________

(Address, City, St, Zip) ______________________________

(Phone) ______________________________ *(Fax)* ______________

for the purpose of: ______________________________

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By signing this authorization:

- *I authorize the use or disclosure of my protected health and confidential information as described above for the purpose listed. I understand that this authorization is voluntary.*
- *I understand that I have a right to receive a copy of this authorization.*
- *A fee may be charged for copying information that you request to be released, but fees will comply with applicable state law.*
- *I understand that I may revoke this authorization at any time by submitting a signed letter addressed to my therapist at the above address or fax. If revoked, the authorization will stop on the date the request is received or specified in the revocation letter. [45 C.F.R. § 56.11(h)] I understand that a revocation is ineffective for any information released prior to the date the notice of revocation has been received by my therapist.*

If not revoked, this authorization shall terminate at the end of (check one):

☐ 6 months ☐ 1 year or ☐ Specify Date or Circumstance ______________

______________________________ ______________
Signature of Client — Date

______________________________ ______________
Signature of Parent/Guardian/Conservator, if applicable — Date