thrive
CENTER FOR PSYCHOLOGICAL HEALTH

Authorization for Release/Exchange of Information

This form provides your therapist with written permission to communicate with other individuals regarding your treatment (e.g., previous therapist, current health care providers, parent).

I, _____, authorize **Dr.**_____ to release and/or exchange information about my case with the following parties:

Name/Relation: _____ **Name/Relation:** _____
Address: _____ **Address:** _____
_____ _____
Phone Number: _____ **Phone Number:** _____

Name/Relation: _____ **Name/Relation:** _____
Address: _____ **Address:** _____
_____ _____
Phone Number: _____ **Phone Number:** _____

Information to be Released or Exchanged (check all that apply)

____ Intake and history
____ Diagnosis and Treatment Plan
____ Verbal Consultation
____ Other (specify)_____
_____

____ Treatment Progress
____ Discharge Summary
____ Billing & Payment
____ **All of the Above**

This release shall be valid until the termination of treatment or until withdrawn in writing by the patient during the course of treatment.

Patient Name: _____

Patient Signature: _____

Parent Signature if under 18 _____

Date: _____