



## AUTHORIZATION FOR RELEASE AND EXCHANGE OF INFORMATION

### Client Information

Client Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

### 1. Parties Authorized to Exchange Information

I authorize:

Psychologist / Practice Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

To release information to and obtain information from:

Person/Organization: \_\_\_\_\_

Relationship / Type of Provider: \_\_\_\_\_

Address: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_

## 2. Information to be Shared

*(Initial or check all that apply)*

- Treatment dates and attendance
- Diagnosis
- Treatment summary
- Psychological evaluation/testing results
- Medication information
- Care coordination information
- Educational records
- Billing/payment information
- Other: \_\_\_\_\_

### Excluded Information (if any)

- Psychotherapy notes
- Substance use treatment records
- Other: \_\_\_\_\_

## 3. Purpose of Disclosure

*(Check all that apply)*

- Coordination of care
- School accommodations
- Insurance purposes
- Other: \_\_\_\_\_
- Continuity of treatment
- Legal matter
- Personal use

## 4. Expiration

This authorization will expire on:

\_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

OR

Upon completion of treatment

OR

Other event: \_\_\_\_\_

## 5. Client Rights and Understanding

I understand that:

- I may revoke this authorization at any time by providing written notice, except to the extent action has already been taken.
- My records are protected by federal and/or state confidentiality laws, including HIPAA.
- Information disclosed under this authorization may no longer be protected if redisclosed by the recipient.
- I do not have to sign this form to receive treatment unless the disclosure is necessary for services.

## 6. Signature

Client / Legal Guardian Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

### **If Signed by Legal Representative**

Representative Name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Authority to Sign: \_\_\_\_\_