

Authorization to Release and Obtain Information

The purpose of obtaining and/or disclosing information is to support the best possible therapeutic outcomes. This may include collaboration with other members of the team working with you or your child, including information related to diagnoses, medical conditions, psychiatric or psychological conditions, test results, evaluations, progress reports, treatment plans, therapeutic services, and non-medical information.

Information disclosed will be used solely for purposes of care coordination and treatment.

Client Information:

Name:	DOB:	Phone Number:

I hereby authorize Blue Skies Behavioral Group to obtain and disclose confidential and protected information to the following organizations or providers (including, but not limited to, medical providers, insurance companies, employers, schools, government agencies, and clinics):

	Provider Name/ Organization	Type of Therapy or Service	Contact Information (Phone, fax, or email)
1			
2			
3			
4			
5			

Type of Authorization

- ☐ Authorize both release and obtaining of information
- ☐ Authorize release of information only
- ☐ Authorize obtaining of information only

Duration and Revocation

This authorization will become effective on the date signed by the client, parent, or legal guardian and will remain in effect until revoked in writing.

This authorization must be renewed every 12 months.

By signing this document, you acknowledge that you understand consent is voluntary and may be revoked in writing at any time.

I have had the opportunity to ask questions and receive clarification in my preferred language.

I hereby authorize the release and obtaining of the information described above.

Signatures

Client Name: _____

Parent/Legal Guardian Name: _____

Relationship to Client: _____

Signature: _____

Date: _____