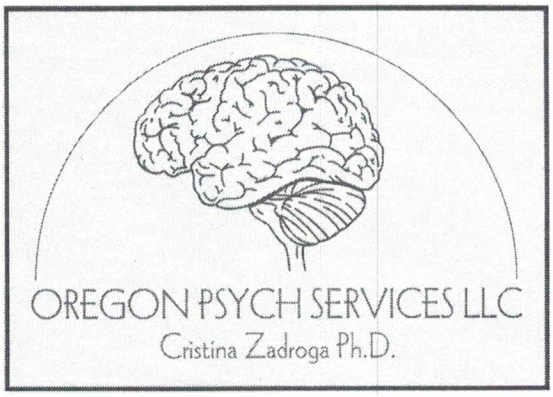


AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name:_____ DOB:_____

Information to be released:

☐ Summary of treatment to date
☐ Report
☐ Other: _____

Purpose of Disclosure:

☐ Coordination of Care
☐ Other: _____

Persons authorized to make Disclosure:

_____

Person authorized to receive Disclosure:

_____

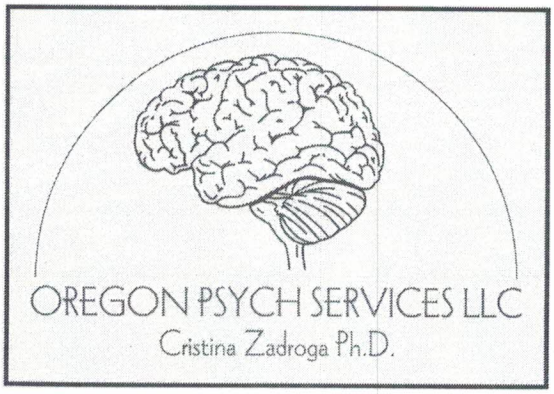
Method of Disclosure and instructions:

☐ Written : _____

☐ Verbal: _____

☐ Electronic: _____

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 Client:_____ Date : _____

Signature of Personal Representative:_____ Date: _____