Liffey Health Intensive Outpatient Program (IOP)
1171 Homestead Rd, Ste 295
Santa Clara, CA 95050

Phone: (669) 201-4949 • Fax: (669) 295-1513 • E-mail: AskUs@LiffeyHealth.com

Authorization to Release Confidential Information

I, _____ (Client) hereby allow _____ (Provider) to release information obtained during the course of my treatment to:

Liffey Health Intensive Outpatient Program
1171 Homestead Rd, Ste 295, Santa Clara, CA 95050
E-mail: AskUs@liffeyhealthcom
Phone: (669) 201-4949
Fax: (669) 295-1513

This Authorization permits the release of the following information:

_____Diagnosis ____Treatment Plan ____Progress to Date
_____Prognosis ____Clinical Test Results ____Dates of Treatment
_____Any and All Information Necessary
_____Other (Specify):

I authorize the release of the information described above for the following purpose(s):
_____ Referral to Liffey Health
_____ Care coordination with _____ (Provider)
_____ Other (Specify):

Liffey Health may contact me through the following methods:
Phone number:
E-mail Address:
Mailing Address:

I understand that I have a right to receive a copy of this Authorization and that any modification or revocation of this Authorization must be in writing.
The Authorization shall remain valid until: _____(Date)

By: _____ Date:
(Client or Client's Representative)

_____
Relationship to Client (if signed by Client's Representative)