

# Consent for Release of Information

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I \_\_\_\_\_ hereby authorize release of treatment records to & from:

Name/Agency: \_\_\_\_\_

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

This release pertains to services rendered to:

Name: \_\_\_\_\_ D.O.B. \_\_\_\_\_

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

This signed release authorizes release of the items checked and initialed below:

- |  |  |
|--|--|
| <input type="checkbox"/> _____ Intake Information            | <input type="checkbox"/> _____ Mental Health Information/Evaluations           |
| <input type="checkbox"/> _____ Treatment Performance Records | <input type="checkbox"/> _____ Letters written on behalf of patient            |
| <input type="checkbox"/> _____ Progress Notes                | <input type="checkbox"/> _____ Exchange of Information (verbal and/or written) |
| <input type="checkbox"/> _____ Other _____                   |  |

The requested information is intended for the recipient identified on this sheet only and privacy laws prohibit further disclosure. By way of illustration and not by way of exhaustion, these laws include those listed under the Health Insurance Portability and Accountability Act (HIPAA) of 1996. It is the policy of this office to not release third party information or any records not originally produced by this office. Such information must be obtained by writing to the other entity directly.

A reproduction of this authorization form shall be considered as the original. I understand that by law I do not have to release this information, but I choose to do so voluntary. I further understand that I may cancel this authorization by specifying such, in writing, at any time. I understand that written withdrawal of this authorization prevents any future release of information, but does not protect against information that was sent prior to receipt of withdrawal of release. If I do not exercise my right to withdrawal this release it shall automatically expire in 24 months from the date of authorization below.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date of Authorization

\_\_\_\_\_  
Guardian/Parent/Authorized Representative

\_\_\_\_\_  
Witness/Therapist Signature