AUTHORIZATION TO RELEASE/RECEIVE HEALTH INFORMATION

Patient Name:_________________________________SS #______________________DOB______________

HomeAddress:____

I hereby authorize and request: _______________________________
Name of Therapist

To obtain from To release information to

Therapist:____

SPECIFY INFORMATION TO BE DISCLOSED:

Entire Medical Record Summary of Treatment

Psychological Evaluation Other (Specify)___________

Progress Notes Pertaining to Date of Service: from:_____________to:_____________

TERMS: The Authorization will remain in effect:

From the date of this Authorization until ________________

Until the following event occurs: **I am no longer a patient of the practice.**
Other:____
(**If unspecified the authorization will expire in six months).**

By my signature below, I hereby authorize the Practice to use or disclose to the recipient my health information for the term of this Authorization for the following specific purpose(s):

At the request of the patient (if the patient is initiating this Authorization), or

Specify the purpose(s):____

I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to your office address. However, my revocation will not be effective to the extent that action has been taken in reliance on the Authorization.

I understand that treatment is not conditioned on whether or not I sign this Authorization except (1) if my treatment is related to research; or (2) if health care services are provided solely for the purpose of creating protected health information for disclosure to a third party.

________________________	________________________	__________
Patient Name	Patient Signature	Date
________________________	________________________	__________
Parent or Legal Guardian Name	Parent or Legal Guardian Signature	Date

THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALITY IS PROTECTED BY STATE STATUE. STATE STATUE LIMITS YOUR RIGHT TO MAKE ANY FURTHUR DISCLOSURE OF THIS INFORMATION WITHOUT THE PRIOR CONSENT OR AUTHORIZATION OF THE PERSON TO WHOM IT PERTAINS.