CONSENT FOR 3RD PARTY INFORMATION RELEASE

CLIENT NAME:

EMAIL ADDRESS:

DATE OF BIRTH:

PHONE NUMBER:

DATE OF AUTHORIZATION EXPIRY:

INFORMATION TO BE RELEASED:

One-page summary of treatment to date
Report
Other: _____

PURPOSE OF DISCLOSURE:

Coordination of Care
Other: _____

PERSONS AUTHORIZED TO MAKE DISCLOSURE:

PERSONS AUTHORIZED TO RECEIVE DISCLOSURE:

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: _____ **TODAY'S DATE:** _____