
Appendix E: Release of Information

Authorization to Release/Exchange Confidential Information

I authorize [name of clinician] to:

- release to:
- obtain from:
- exchange with:
 - Name: _____
 - Address 1: _____
 - Address 2: _____
 - Phone: _____
 - Fax: _____
 - Email: _____

the following information on behalf of [name of client]:

- treatment summary
- history/intake
- diagnosis
- psychological test results
- dates of treatment attendance
- other (specify) _____

for the purpose of:

- evaluation
- care coordination
- other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time in writing (except to the extent that the information has already been released).

Client's Signature

Client's Date of Birth

Client's Name

Clinician's Signature

Parent/Guardian's Signature
(as applicable)

Date