

AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS & INFORMATION

Patient/Client Name	Date of Birth	Social Security Number
hereby authorize	to: re	lease to and/or obtain from:
Person or Facility:	Phone:	Fax:
·	City/State/Zip:	
Confidential record information and/or testing results	on the above patient/client for the fol	lowing purpose(s):
☐ Continuity of Care ☐ Insurance or other 3rd		
These records concern the time between	and	
The information to be disclosed is marked by an X in	the boxes below:	
☐ Intake and discharge summaries	☐ Medical history and evaluation(s)	
☐ Mental health evaluations	☐ Developmental and/or social history	
☐ Educational records	☐ Progress notes and treatment or closing summary	
☐ Telephone consults	Other	
cated here: Do Not Release You have the right to revoke this authorization, in writi	ng, at any time by sending such writte	to notification to my office address. However
You have the right to revoke this authorization, in writi your revocation will not be effective to the extent that obtained as a condition of obtaining insurance coverage I understand that my health care provider/counselor gunless the services are provided to me for the purpose of	t I have taken action in reliance on the great the insurer has a legal right to be greatly may not condition providing	on notification to my office address. However the authorization or if this authorization was contest a claim. If services upon my signing an authorization
	t I have taken action in reliance on the geand the insurer has a legal right to be generally may not condition providing of creating health information for a thin uant to the authorization may be sub-	on notification to my office address. However the authorization or if this authorization was contest a claim. If services upon my signing an authorization and party. I also understand that I may inspendent to redisclosure by the recipient of you
You have the right to revoke this authorization, in writi your revocation will not be effective to the extent that obtained as a condition of obtaining insurance coverage. I understand that my health care provider/counselor gunless the services are provided to me for the purpose or have a copy of the information to be released. I understand that information used or disclosed purs information and no longer protected by the HIPAA Pr	t I have taken action in reliance on the geand the insurer has a legal right to be generally may not condition providing of creating health information for a thin uant to the authorization may be sub-	on notification to my office address. However, the authorization or if this authorization we contest a claim. If services upon my signing an authorization and party. I also understand that I may inspendent to redisclosure by the recipient of you
You have the right to revoke this authorization, in writing your revocation will not be effective to the extent that obtained as a condition of obtaining insurance coverage. I understand that my health care provider/counselor gunless the services are provided to me for the purpose of or have a copy of the information to be released. I understand that information used or disclosed pursinformation and no longer protected by the HIPAA Print it is signed.	t I have taken action in reliance on the ge and the insurer has a legal right to be generally may not condition providing of creating health information for a thin uant to the authorization may be subjected Rule. This consent will expire activacy Rule.	en notification to my office address. However, ne authorization or if this authorization was contest a claim. If services upon my signing an authorization and party. I also understand that I may inspect to redisclosure by the recipient of you atomatically one year from the date on which

whom it pertains or as provided by such regulations.