**AUTHORIZATION FOR RELEASE OF INFORMATION**

I hereby authorize Deborah Anthony, LMHC to (please check):

Obtain \_\_\_ Release X\_\_\_\_ Exchange \_\_ the following

Written \_\_\_ verbal \_\_\_\_ electronic \_\_\_\_ video \_\_\_\_ audio information (please check):

|  |  |  |
| --- | --- | --- |
| \_\_ Treatment Plan  \_\_ Social History  \_\_ Psychiatric Evaluation  \_\_ Discharge Summary | ­­\_\_ Psychological Evaluation  \_\_Educational Information  \_\_Behavioral Observation | \_\_ Physical Exam  \_\_ Medical Treatment  \_\_ Alcohol/drug treatment |

\_\_ Other (specify) \_\_\_\_\_

(In compliance with FS 90.503, 394.459(9), 395.3025(2)(3), 397.501(a) and Federal Regulations 2 CFR, Part 2 and HIPAA regulations.)

Information from the records of:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To/From: \_\_\_\_

Client Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, State, Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth

For the purpose of (please check): \_\_\_ to assist in the evaluation and treatment of the client

\_\_\_ Other: \_\_\_

A signed revocation may be submitted at any time but Deborah Anthony, LMHC shall not be held liable for any information release prior to its receipt. This release form shall be valid for:

\_\_\_ A single disclosure \_\_\_ A continuing disclosure for 90 days for date below \_\_\_ A continuing disclosure for 1 year from the signature date below.

**To Receiving Party/Agency:**

PROHIBITION OF REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected. Any further disclosure is strictly prohibited unless the client provides specific written consent for the subsequent disclosure of this information. A general authorization for the release of medical or other information is not sufficient to waive confidentiality of these records.

I acknowledge that I have read this authorization and fully understand its contents.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

When requesting information, send original. When sending information, keep original in chart.

**AUTHORIZATION FOR RELEASE OF INFORMATION**

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|  |  |  |
| --- | --- | --- |
| \_\_ Treatment Plan  \_\_ Social History  \_\_ Psychiatric Evaluation  \_\_ Discharge Summary | ­­\_\_ Psychological Evaluation  \_\_Educational Information  \_\_Behavioral Observation | \_\_ Physical Exam  \_\_ Medical Treatment  \_\_ Alcohol/drug treatment |

\_\_ Other (specify) \_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ To/From: \_\_\_\_

Client Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address

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City, State, Zip

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of Client Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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