Therapy Changes
Focused guidance when you need it most

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AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

____ Name of Client

________________________ Date of Birth

I, ____, hereby authorize Therapy Changes (hereinafter "Provider") to disclose/exchange mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to therapist's diagnosis, of the client listed above to:

____ Name

________________________ Phone

____ Address

________________________ Fax

____ City State Zip

I am requesting this disclosure of information and records for the following purpose:

☐ At the request of the individual
☐ Other: ______________________________________

The specific uses and limitations of the types of health information to be released are as follows:
(Check all that apply)

☐ Treatment Coordination
☐ Treatment Planning
☐ Diagnostic Refinement
☐ Other: ______________________________________

Such disclosures shall be limited to the following specific types of information:

☐ Psychiatric diagnosis(es)
☐ Dates of Treatment
☐ Treatment Summary
☐ Initial Treatment Plan
☐ Full Treatment Record
☐ Other: ______________________________________

This authorization shall remain valid until: ________________________________ (not to exceed one year)

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider to be effective.

Provider shall not condition treatment upon my signing this authorization and I have the right to refuse to sign this form. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

____ Signature of Client

________________________ Date

____ Signature of Legal Guardian, Relationship to Client

________________________ Date