Therapy Changes
*Focused guidance when you need it most*

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# AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

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

| | |
|---|---|
| Name: | |
| Address: | |
| | |
| Telephone: | Fax: |

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.

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 ☐ Diagnostic Refinement
☐ Treatment Planning ☐ Other: _____

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

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

Provider shall not condition treatment upon Client signing this authorization and Client has 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.

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

_____ _____
Client's Signature Date