Therapy Changes
Focused guidance when you need it most

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Authorization to Release Information

_____ _____
Name of Client Date of Birth

I authorize Therapy Changes (hereinafter "Provider") to disclose 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 of Individual or Organization Phone

_____ _____
Address Fax

_____
City State Zip

I authorize Therapy Changes to send the following information: (Check all that apply)

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

The above information will be used for the following purposes: (Check all that apply)

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

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 understand that this authorization will automatically expire after 1 year.

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 Date

Your relationship to the client: ☐ Self ☐ Other*

If other, please provide your legal name and relation to the client:

_____

*If you are not the client, you may be asked to provide documentation on your authority to act on behalf of this individual.