Therapy Changes
Focused guidance when you need it most

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Authorization to Release Information

Name of Client _____ Date of Birth _____

Name of Provider Releasing Information _____

I authorize the provider listed above to disclose mental health treatment information and records obtained in the course of psychotherapy treatment, including provider's diagnosis of the client listed above to:

Name of Individual or Organization Receiving Information _____ Phone _____

Address _____ Fax _____

City _____ State _____ Zip _____

I authorize the release of the following information: (Check all that apply)

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

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

- ☐ Treatment Coordination
- ☐ Diagnostic Refinement
- ☐ Treatment Planning
- ☐ 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 the authorized provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by the authorized provider to be effective. I understand that this authorization will automatically expire after 1 year.

The authorized 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.