# Release of Information

Client Name: _____ Social Security #: _____

I authorize this therapist _____, to release to and/or receive from:

_____ _____
**Name/Title** **Agency/Organization**

_____
**Address (City, State, Zip)**

_____
**Phone**

**The following records and/or information:** *(client initials applicable section)*

_____ Psychological/Psychiatric
_____ Therapy/Counseling
_____ Employment
_____ Educational
_____ Social History
_____ Military
_____ Medical
_____ Drug/Alcohol
_____ Evaluations/Reports
_____ Other _____
Specify

**The purpose of releasing/exchanging information is:**

_____ To contribute to evaluation/assessment
_____ To assist with treatment planning
_____ Other _____
Specify

**I understand that any records disclosed by this therapist under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. All records received by this therapist will remain confidential and will not be disclosed except as provided by this release. I further understand that this therapist cannot make any decisions regarding treatment, payment, enrollment, or eligibility for benefits based on this authorization. I permit this authorization for one year from the date of signature. I understand this authorization may be revoked at any time by providing written notice to this therapist. I understand a copy of this release is as valid as the original.**

**This authorization will expire on the following date or event:**_____
**Expiration Date** *(1 year from signing date)*

_____ ____/____/____
**Client Name** (Print) **Date**

_____ _____
**Client Signature** **Witness**

_____
**Signature of Parent/Guardian**