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Consent to Release Protected Health Information

Patient Name_____ Date of Birth_____

I, _____, hereby authorize

_____ To release and receive information
(Name of Therapist)

To the Agencies/Providers listed below for the purposes of: (check all that apply)

_____ Coordination of Treatment

_____ Consultation

Information to be released/received includes:

_____ Assessment and Diagnosis

_____ Treatment Summary and Recommendations

_____ Dates of Treatment

_____ Other _____

Agencies/Individual Providers	Address	Phone	Fax
_____	_____	_____	_____
_____	_____	_____	_____

This authorization for release of protected health information is specifically limited to the Information specified above and is made in accordance with the Health Insurance Portability and Accountability Act (HIPPA). State and Federal Laws prevent disclosure of your protected health information without your consent. This release shall remain in effect until 90 days after discharge from treatment.

_____ _____
Client Signature Parent/Legal Guardian Signature (If client is a minor)

_____ _____
Date Witness