Authorization to Release Confidential Information

Name of patient: _____ Date of birth: _____

I understand that the purpose of this release is to assist with my/this patient's treatment by improving communication between professional service providers or agencies and the important individual(s) in my/the patient's life. To further this goal, I authorize **Clarity Counseling Associates** to release the below-specified information regarding me/the patient to the individual(s) listed below, and to receive information from them. I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

The information to be disclosed is marked by an X in the boxes below, and any items not to be released have a line drawn through them:

❑ Name of therapist ❑ Name of case manager ❑ Name(s) of treatment program(s)
❑ Admission/discharge information ❑ Treatment plan ❑ Scheduled appointments ❑ Progress notes
❑ Compliance with treatment ❑ Discharge plans ❑ Treatment summary ❑ Psychological evaluation
❑ Medications ❑ Other: _____

This information is to be disclosed to these persons, who have the indicated relationship to me/the patient:

_____ _____
Name of person Relationship

_____ _____
Name of person Relationship

_____ _____
Name of person Relationship

_____ _____
Name of person Relationship

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire ❑ one year from this date, ❑ upon my discharge from treatment by this agency or by the person specified above, or ❑ under these circumstances: _____.

_____ _____ _____
Signature of client or parent/guardian Printed name Date