Authorization for Release of Information - Adult

I, _________________________________, with my signature below, give authorization for Amy Gray, LICSW, to release and receive the specific health information described below with:

Name of Person or Agency: ____

Address: ____

____

Telephone: ____________________________ Fax: ____

Information discussed is to be limited to:

[ ] Confirmation of Services

[ ] Diagnosis | [ ] Discharge/Treatment Summary

[ ] Entire Psychological Record | [ ] Other

____

[ ] With the following exceptions: ____

The information is to be disclosed for the purpose of:

[ ] Evaluation or Diagnosis

[ ] Continuity of Care / Coordination of Services

[ ] Other____

You may revoke this authorization in writing at any time. To revoke this authorization, send a written statement to Amy Gray, LICSW at the address listed below.

I hereby authorize the following:

_______ (initial) Release of my records via FAX machine. I accept the risk of misdirected information via misdialed phone number and misdirected release within the receiving facility/company.

This authorization shall expire one year from the date signed.

Client Signature: _____________________________________ Date: __________________

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