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RELEASE OF INFORMATION

PATIENT NAME: _____ **DATE OF BIRTH:** ____ / ____ / ____

ADDRESS: _____ **PHONE:** (____) _____

I, (or on behalf of) _____ (patient name) give permission to the individuals or organizations listed above to exchange information about my medical history. This includes any treatment related to psychological care. The purpose of this release is to allow continuity of care among my health care providers including carrying out discharge arrangements and to determine clinical eligibility for covered benefits.

Individual or Organization: _____

Address: _____

Phone/Fax/Email: _____

If there are any limitations about the release of information, they are written here:

Signature of Client or Guardian: _____ Date: _____

Signature of Therapist/Witness: _____ Date: _____

I refuse to release information as described above.

Signature: _____ Date: _____