Request for Information

The SUMMIT Therapy Center
4419 Cleveland Rd, Wooster, OH 44691
Ph: (330)345-8450 Fax: (330)345-5899

To the agency or clinician referred to below:

_____Please send a summary, or photocopies, of the information which our mutual client/patient has agreed below to release.

_____Please keep this form on file in case either of us feels a need to consult by phone or otherwise communicate about this client.

Authorization for Release of Information

I, _____, consent to a release of information about:
(name of client or guardian with the power to authorize release of information and state relationship)

_____ or circle: myself.
(client's name if not the same as above or circle "myself")

___To ___ From: _____at Summit Therapy.
Name of Summit psychotherapist, and office manager if needed

___To ___From _____
Name of clinician or other person familiar with the client

Information to be released:

____Assessment/Diagnostic/Testing materials ____ Treatment plans

____Summary of progress ____ Other please specify:_____

Restrictions (any information that must NOT be released): _____
The purpose of this release of information:

____Diagnosis ____Treatment planning

____Coordination of services ____Other please specify:_____

This authorization of release/disclosure of information shall remain in effect until:

_____Completion of treatment here ____Other date/event/condition please specify :

I understand that: 1) I have a right to decline signing this authorization; my psychotherapist may not make this release a precondition for treatment unless the generation of health information for a third party is the purpose of treatment here. 2) I have the right to revoke this authorization at any time by sending a written notification to Summit Therapy and/or to the other party named on this form. 3) When my therapist discloses information, the recipient could re-disclose it to a third party, which means it is no longer protected by HIPPA Privacy regulations.

_____ _____ _____
Signature: Client or Gaurdian (state relationship) Printed Name Date

_____ _____ _____
Signature: Psychotherapist, with credentials Printed Name Date