AUTHORIZATION TO RELEASE INFORMATION

This form authorizes the release of protected information from your clinical record to/from the person/entity you designate. A separate release form must be completed for each different person/entity you are designating.

I, _____ (*print name)*, DOB _____, authorize my provider, Amy Craig-Van Grack, LCSW-C and/or administrative staff of BPC&C to *(check only one)*:

☐ **release** ☐ **obtain** ☐ **exchange**

the following information:

☐ Billing Information ☐ Treatment Plans

☐ Intake Evaluation ☐ Discharge Summary

☐ Progress Notes ☐Other (Please specify:_____)

Please specify any limitations for this release (*any information you do **NOT** authorize for release*):

_____

_____

This information may only be released to:_____

(Person/Entity) (Telephone)

_____

(Street Address) (City, State) (Zip Code)

The purpose of this release of information is:_____

☐ At my request (*if you prefer not to state a specific purpose*)

I understand that the recipient of the released information cannot re-disclose any information to/from another health care provider.

This authorization shall remain in effect for one year from the date of my signature below or until:_____

_____

(Please specify a specific date or relevant event that is sooner than one year.)

I have the right to revoke this authorization in writing at any time by sending such written notification to BPC&C. However, my revocation cannot be retroactive, and the revocation will not be effective if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

_____ _____

Signature of Client or Parent/Guardian* Date

_____ _____

Print Name Relationship to Client

_____ _____

Print Client's Name Client's DOB

*If parents are **separated** or **divorced** and have **joint custody** of the client, then both parents' signatures are required.

_____ _____

Signature of Additional Parent Date

_____ _____

Print Name Relationship to Client