COGNIZANT BEHAVIORAL HEALTH SERVICES

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, DOB _____, hereby authorize _____ of Cognizant Behavioral Health Services (CBHS) to (**check one**):

___ release to ___obtain from ___release to and obtain from:

Individual/Organization: _____
Address: _____
_____
Phone: _____ Fax: _____

The following information regarding (**check all that apply**):

___ My current treatment ___ Specific date: _____ ___Services from _____to _____:

___ Psychiatric Intake Evaluation
___ Psychiatric Progress Notes
___ Psychiatric Treatment Summary
___ Psychiatric Treatment Plan
___ Medication Logs
___ Lab Reports
___ Psychological Intake Evaluation
___ Psychological Progress Notes
___ Psychological Treatment Summary
___ Psychological Treatment Plan
___ Phone Consultation
___ Billing Records
___ Psychological Testing Report
___ Neuropsychological Testing
___ Medical History/Treatment
___ Drug & Alcohol Information
___ HIV-related Information
___ Other _____

The information is being released/obtained for the specific purpose of (**check all that apply**):

___ Coordination of Services
___ Treatment Planning
___ Third Party Reimbursement
___ Job/Academic Accommodations
___ Pending Legal Action
___ Disability Claims
___ Other: _____

I understand that this authorization may be revoked in writing at any time, except to the extent that action has already been taken to comply with this request. I understand that authorizing disclosure of this information is voluntary and that I need not sign this authorization in order to receive treatment. This consent will expire automatically 90 days from termination of treatment.

I certify that this form has been fully explained to me, and that I understand its contents.

This consent is valid from _____ to _____ (a maximum of ONE YEAR)

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Guardian/Representative Date

_____ _____
Office Staff Date

___Copy offered: ___ Accepted ___ Declined

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