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Authorization for Release of Information

1. Client's Name: _____ DOB: _____

2. Information to be released:
□ Summary of treatment to date
□ Report
□ Other: _____

3. Purpose of Disclosure
□ Coordination of Care
□ Other: _____

4. Persons authorized to make Disclosure:
_____

5. Person authorized to receive Disclosure:
_____

6. Method of Disclosure
□ Written: _____
□ Verbal: _____
□ Electronic: _____

7. Today's date: _____Authorization to expire on: _____

I understand that my health information is protected by law. I authorize the release of my confidential health information as indicated above. I understand that my consent is voluntary, and I can revoke this permission at any time, except to the extent that it has already been shared based on this authorization. Should I choose to revoke this authorization I will state this in writing.

_____

Client name (print) Signature Date

_____

Guardian/Parent name (print) Signature Date

_____

Guardian/Parent name (print) Signature Date

_____

Jose Luis Madera, LPC-15266 Signature Date
Therapist