Authorization for Release/Exchange of Information

This form provides your therapist with written permission to communicate with other individuals regarding your treatment (e.g., previous therapist, current health care providers, parent).

I, ______________________________, authorize **Dr.________________________________** to release and/or exchange information about my case with the following parties:

Name/Relation:	____________________	**Name/Relation:**	____________________
Address:	____________________	**Address:**	____________________
	____________________		____________________
Phone Number:	____________________	**Phone Number:**	____________________

Name/Relation:	____________________	**Name/Relation:**	____________________
Address:	____________________	**Address:**	____________________
	____________________		____________________
Phone Number:	____________________	**Phone Number:**	____________________

Information to be Released or Exchanged (check all that apply)

____ Intake and history
____ Diagnosis and Treatment Plan
____ Verbal Consultation
____ Other (specify)______________
____

____ Treatment Progress
____ Discharge Summary
____ Billing & Payment
____ **All of the Above**

This release shall be valid until the termination of treatment or until withdrawn in writing by the patient during the course of treatment.

Patient Name: ____

Patient Signature: ____

Parent Signature if under 18 ____

Date: ________________