

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

Name of Client

Date

I, _____, hereby authorize Therapy Changes hereinafter "Provider") to disclose/exchange mental health treatment information and records obtained in the course of psychotherapy treatment, including, but not limited to therapist's diagnosis, of the client listed above to:

Name

Phone

Address

Fax

City

State

Zip

I am requesting this disclosure of information and records for the following purpose:

At the request of the individual

Other: _____

The specific uses and limitations of the types of health information to be released are as follows: (Check all that apply)

Treatment Coordination

Treatment Planning

Diagnostic Refinement

Other: _____

Such disclosures shall be limited to the following specific types of information:

Psychiatric diagnosis(es)

Dates of Treatment

Treatment Summary

Initial Treatment Plan

Full Treatment Record

Other: _____

This authorization shall remain valid until: (not to exceed one year): _____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider to be effective.

Provider shall not condition treatment upon my signing this authorization and I have the right to refuse to sign this form. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

Client Print

Signature

Date

Guardian Print

Signature

Date