AUTHORIZATION FOR RELEASE OF INFORMATION

Name: ______________ Date of Birth: ____________ Phone: ________________

Patient Rights

- You may end this authorization any time by contacting our office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your service will not be affected.

Patient Authorization

I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding my counseling related information such as treatment plan; dates of treatment; progress notes, and discharge summary, etc. I authorize these agencies to share information by mail, phone, in person, fax and/or email contact. I understand that these records are protected by federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

☐ I hereby authorize _____________________ to RELEASE my protected health information(PHI) to:

____

☐ I hereby authorize _____________________ to OBTAIN my protected health information (PHI) from:

____

Disclosure Scope for PHI Release:

Disclosure may include the following verbal or written information: (check all that apply)	
☐ Treatment Plan	☐ Progress Notes
☐ Dates of treatment	☐ Discharge summary
☐ Other:	☐ Exclusion (items not to be disclosed):

How would you like this information communicated?

☐ Verbal discussion
☐ Written information
☐ Other: _______________________

I understand that unless otherwise limited by state or federal regulation and except to the extent that action has been taken which was based on my consent, I may withdraw this consent at any time.

________________________________ ________________
Signature of Client Date

________________________________ ________________
Witness Date

____

Office use only:
Information release note:
Signature: ______________ Date: ____________________

The Chinese Authorization for Release is translated from this English file