Melody Richards
Counselor • Speaker • Author

AUTHORIZATION TO RELEASE INFORMATION

Client's Name ___________________________________

Birthdate ________________

I hereby authorize ____ and:
(Therapist's Name)

____
Professional's Name/Organization

____
Address

____
City, State, Zip

____
Phone

____
Professional's Name/Organization

____
Address

____
City, State, Zip

____
Phone

To exchange the following information (check all that apply):

_______ Phone Consultation
_______ Social History
_______ Diagnosis
_______ Psychological Tests
_______ Progress Notes
_______ Discharge Summary
_______ Treatment Plan
_______ Medical History
_______ Chemical Dependency Evaluation
_______ Other ____________________

This information is needed for the following purpose:

1. To affect a continuum of care for the client's recovery
2. Other ____

I understand that I may revoke this authorization, in writing, at any time and that upon fulfillment of the above stated purpose, this authorization will expire. In any case, this authorization will automatically expire one year from the date signed.

____
Client Signature

____
Date

____
Client Signature

____
Date