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 exp	
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.		
Signatu	are of Patient:	Date:
Signature of Personal Representative:		