AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION: Adult Format

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Since all communications made within the confines of a psychotherapeutic relationship are confidential, it is necessary for this office to request a signed authorization in order to release or obtain any information related to this type of relationship.

RE: _____ _____
Name of Patient Date of Birth

I, _____, hereby authorize _____

at _____ to release, disclose

or discuss confidential information regarding my treatment/evaluation/assessment/health

care to the person/organization listed below:

_____
Name

_____
Address

_____
City/Zip/Phone

_____
Fax No.

It is the understanding of the above named individual that this information will be

shared for the following purpose(s): _____.

and should include: _____.
(description of records requested)

This release of information may be revoked at any time and will expire 6 months from the date of the signature below.

_____ _____
Authorized Signature Date

_____ _____
Witness Date