Patient Name

Date of Birth

I understand that the purpose of this release is to assist with my/this patient's treatment by improving communication between professional service providers or agencies. To further this goal, I authorize this specific clinician <insert Clinician's name>, to release the below-specified information regarding me/the patient to the individual(s) listed below, and to receive information from them. I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

Select the items that are permitted to be disclosed. Any items not selected will not be disclosed.

- [ ] Treatment Plan
- [ ] Compliance with Treatment
- [ ] Psychological Evaluation
- [ ] Progress Notes
- [ ] Genogram and Psychosocial History
- [ ] Treatment Summary
- [ ] Other (fill in the specifics in the text field below)

Other Disclosures

This information is to be disclosed to these persons, who have the indicated relationship to me/the patient:

Name of Person

Relationship

Name of Person

Relationship

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon.

This release will expire:

- [ ] One year from now
- [ ] Upon my discharge from treatment by
- [ ] Under the following circumstances described below

Additional circumstances under which this release will expire:

Typed Name of Client or Represenative

Relationship to Patient (if not Patient)

Date