**Release of Confidential and Protected Health Information**

**Client Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date authorization initiated \_\_\_\_\_\_\_\_\_\_\_**

**Information to be released:**

**Written or verbal communication about my treatment without any restrictions: \_\_\_\_\_**

**I request the following restrictions in the release of my protected health information:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Individual allowed to release information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Individual allowed to receive information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Client signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date signed: \_\_\_\_\_\_\_\_\_\_**

**Witness signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* **You do not have to sign this release of information authorization and failure to sign will not in any way effect your right to receive quality treatment.**
* **You may revoke this authorization at any time by sending written notification, except to the extent that action has already been taken based on this authorization. If not revoked, this authorization will expire with the termination of treatment.**
* **These records may include psychiatric and/or substance abuse information.**