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| **AUTHORIZATION TO RELEASE OR EXCHANGE INFORMATION** |

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| **PATIENT INFORMATION** |

Clients Name:

Address:

City, State, ZIP:

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **OTHER PARTY** |

Name of Person/Organization:

Address:

City, State, ZIP: \_\_\_\_Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **INFORMATION TO BE RELEASED** |

I hereby authorize Family Psychiatric Care, LLC to (please initial all that apply)

\_\_\_\_\_\_Release Information to \_\_\_\_\_\_Gather Information from \_\_\_\_\_Exchange Information with

This information may consist of the following (Please initial each line to which consent is given:

\_\_\_\_\_\_\_Psychological test reports

\_\_\_\_\_\_\_Psychiatric evaluation reports

\_\_\_\_\_\_\_Periodic reports of psychotherapy

\_\_\_\_\_\_\_Social history data; including family, education employment, arrest, drug and alcohol information

\_\_\_\_\_\_\_Medical Information

\_\_\_\_\_\_\_Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This information will be used (please initial each line to which consent is given):

\_\_\_\_\_\_\_To determine appropriateness of treatment

\_\_\_\_\_\_\_To develop a diagnosis and treatment plan

\_\_\_\_\_\_\_To facilitate coordination of services

\_\_\_\_\_\_\_At the request of the individual

\_\_\_\_\_\_\_Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **ACKNOWLEDGMENT** |

I understand that no information may be forwarded by either party listed in this release to any other individual or agency without my written consent. I understand that this information may not be redisclosed by its recipient. This authorization may be revoked at any time by my written statement except to the extent that authorized persons who are to disclose the information described above have already taken action in reliance on it. It is automatically revoked 30 days after the termination of the therapeutic relationship or under the following conditions:

This consent is given voluntarily, without coercion. Signing this form is not required to receive treatment/services at Family Psychiatric Care LLC.

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Client Date Staff Signature Date