RELEASE OF INFORMATION

Client Information	Name _____ Date of Birth _____ Address _____ City _____ State _____ Zip Code _____ Phone Number_____
Clinic/Health Care Provider Who has the information to be released?	Name _____ Address _____ City _____ State _____ Zip Code _____ Phone Number_____ Fax Number _____
Receiving Party Who will the information be released to?	Name _____ Relationship to Client_____ Address _____ City _____ State _____ Zip Code _____ Phone Number_____ Fax Number _____
Information to Be Released What will be released?	□Whether the client is in treatment or not □Prognosis (diagnosis, opinion of how treatment will benefit client, general peculiarities of case) □Nature of the project (Services offered, purpose and philosophy of program) □Brief statement regarding progress (client's denial, client's understanding of their condition and the disease concept, progress or lack of progress on goals, cooperation with treatment plan and rules) □Brief statement regarding relapse and frequency of relapse (cannot identify specific drugs)
Purpose of Release Why is information being released?	□Referral to other services □Coordination of care □Consultation with Doctor □Consultation with other mental health provider □Transfer of care □Other _____

Signature of Client _____

Date_____

Signature of Provider _____

Date_____

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____.