AUTHORIZATION FOR THE DISCLOSURE AND RECIPROCAL EXCHANGE OF INFORMATION

Client Name: ____________________________DOB: _______Record #: ______________________

I, _______________________________________, hereby authorize **Therapist** to share specified protected health information in my/my child's medical record with **Therapist** located at ______________________________. I further authorize **Therapist** to release specified protected health information in my/my child's record to ______________________ .

The purpose of the disclosure: Assist with treatment Referral At Request of Client

Other____

This information shall include only the following:

Initial	Information	Date Released	Initial	Information	Date Released
	Treatment Progress Summary			Diagnoses/Psychiatric Information	
	Service Plan Documentation			Discharge Summary	
	Progress Note Documentation			Verbal Communication	
	Alcohol/Drug Treatment Information*			Psychological Information	
	Medical History and Physical			Other (List):	

My right to confidentiality has been explained to me, and I understand the information to be released, the purpose of the release, and the statutes and regulations protecting my confidentiality. I understand that I may revoke this consent at any time, either verbally or in writing, except where releases of information based upon this consent have already occurred.

I understand that the above recipient party, without my further consent, may not release this information, and that **Therapist** is required by HIPAA privacy law to protect my health information. However once **Therapist** discloses information, I understand they have no control over my privacy with regard to the recipient of the information.

This consent will automatically expire on: __________________________ (date, not to exceed one year) or, 90 days after discharge from services, whichever comes first. I may request a copy of this signed authorization.

____ ____________________
Client Signature Date

____ ____________________
Guardian (Relationship to Client) Date

____ ____________________
Therapist Signiture Date

____
Therapist Print

*Client must sign whether a child or adult, information protected by Federal Regulations 42CFR part 2