

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Client Name: _____ Date of Birth: _____

Social Security #: _____

I request and authorize _____ to
 obtain release health care information of the patient named above verbally or in writing to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This authorization applies to the following treatment or condition: _____

For Treatment Date(s): _____ to _____

- | | | |
|--|---|--|
| <input type="checkbox"/> Admission Summary | <input type="checkbox"/> Psychological Tests | <input type="checkbox"/> Physical Exam |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Psychiatric Diagnosis Only | <input type="checkbox"/> Lab Reports |
| <input type="checkbox"/> Treatment Summary | <input type="checkbox"/> Drug/Alcohol Abuse Related Info. | <input type="checkbox"/> Consults |
| <input type="checkbox"/> Treatment Plans | <input type="checkbox"/> Medication notes | <input type="checkbox"/> All Health Care Information |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Current School Adjustment | <input type="checkbox"/> Other-Specify: |

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results.

Yes No I authorize the release of any records regarding drug, alcohol or mental health treatment to the person(s) listed above.

I hereby acknowledge that I fully understand the above statements as they apply to me and that my records cannot be disclosed without my written consent except as otherwise specifically provided by law. I understand that by law, I need not consent to the release of this information, but I choose to do so voluntarily. I further understand that refusal to grant consent to release of information will not jeopardize my right or the client's right to obtain present or future treatment except where disclosure is necessary for treatment.

I further release Intraspectus, LLC from all legal responsibility or liability that may arise from this disclosure, and I understand in good faith that I may revoke my consent at any time, unless action on this release has already begun in good faith. I further understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of this information.

Patient/Guardian
Signature: _____ Relationship: _____ Date: _____

Patient/Guardian
Signature: _____ Relationship: _____ Date: _____

Patient/Guardian
Signature: _____ Relationship: _____ Date: _____

Witness: _____ Date Signed: _____

This Authorization Expires Ninety Days After It Is Signed.