Authorization to Release Confidential information to Family Members

Name of patient:_____

Date of birth: _____Social Security#: _____

I understand that the purpose of this release is to assist with my/this patient's treatment by improving communication between professional service providers or agencies and the important individual(s) in my/the patient's life. To further this goal, I authorize this specific service provider, therapist, case manager, or _____ to release the below-specified information regarding me/the patient to the individual(s) listed below, and to receive information from them.

I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer, and I accept these.

The information to be disclosed is marked by an X in the boxes below, and any items not to be released have a line drawn through them:

_____ Name of Therapist _____ Name(s) of Case Manager _____ Name(s) of Treatment program(s)

_____Admission/Discharge information _____ Discharge Plans _____ Treatment plan

_____ Progress notes _____ Treatment Summary _____ Medications

_____Psychological Evaluation _____ Schedule Appointments _____ Compliance with treatment

_____ Other Information:_____

This information is to be disclosed to the following persons, who have the indicated relationship to me/the patient:

_____

Name of Person Relationship

_____

Name of Person Relationship

_____

Name of Person Relationship

I understand that I may revoke this release at any time, in writing, except to the extent that it has already been

acted upon. This release will expire one year from:_____ or upon my discharge from treatment by this practice or by the person specified above or upon my death.

_____

Patient: Signature: Date:

_____

Parent/Guardian Name: Signature: Date:

_____

Witness Name: Signature: Date: