654 SE Monterey Road . Stuart, Fl 34990. Ph: 772-617-6928 F: 772-382-0535

Authorization for Release/Exchange of Information

This form provides your therapist with written permission to communicate with other individuals regarding your treatment (e.g., previous therapist, current health care providers, parent).

I, ____________________________, authorize ______________________________ to release and/or exchange information about my case with the following parties:

Name/Relation: ____________________________
Address: ____________________________
____
Phone Number: ____________________________

Name/Relation: ________________________
Address: ________________________
____
Phone Number: ________________________

Name/Relation: ____________________________
Address: ____________________________
____
Phone Number: ____________________________

Name/Relation: ________________________
Address: ________________________
____
Phone Number: ________________________

Information to be Released or Exchanged (check all that apply)

____ Intake and history
____ Diagnosis and Treatment Plan
____ Verbal Consultation
____ Other (specify)______________
____

____ Treatment Progress
____ Discharge Summary
____ Billing & Payment
____ **All of the Above**

This release shall be valid until the termination of treatment or until withdrawn in writing by the patient during the course of treatment.

Patient Name: ____

Patient Signature: ____

Parent Signature if under 18 ____

Date: ___________________