UNIQUE
PSYCHOLOGICAL & CONSULTING SERVICES

Authorization for Release of Information

1. Client's Name:_____DOB:_____

2. Information to be released:

☐ Summary of treatment to date

☐ Report

☐ Other: _____

3. Purpose of Disclosure

☐ Coordination of Care

☐ Other: _____

4. Persons authorized to make Disclosure:

_____

5. Person authorized to receive Disclosure:

_____

6. Method of Disclosure

☐ Written : _____

☐ Verbal:_____☐

Electronic: _____

7. Today's date:_____Authorization to expire on: _____

I understand that my health information is protected by law. I authorize the release of my confidential health information as indicated above. I understand that my consent is voluntary, and I can revoke this permission at any time, except to the extent that it has already been shared based on this authorization. Should I choose to revoke this authorization I will state this in writing.

Signature of Patient: _____Date:_____

Signature of Personal Representative:_____