Authorization for the Release of Information

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I _____, authorize _____ and
(client) (therapist)

_____
(name of person(s) or organization(s) which disclosure is to be made to and/or received from)

to disclose to one or the other the following information from my records.

_____ All healthcare information
(initial here)

_____ Health Care or Information or Opinions relating to any or all of the following treatments and/or conditions:

_____ 1. Mental Health Information
(initial here)

_____ 2. Academic and Confidential School Information
(initial here)

_____ 3. Testing
(initial here)

_____ 4. Other _____
(initial here)

For the purpose of treatment/management/supervision of psychological and/or medical conditions I hereby waive my right to the privileges of confidentiality as specified above, for a period of one year after signing this release.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Signature Date