Official Release of Confidential Information

Today's Date:_____

Client Name: _____ Date of Birth: _____

I hereby authorize Starr Burgess to:

☐ obtain information from ☐ release information to

Agency _____

Attention _____

Street Address _____

City, State, Zip _____

Phone Number _____

Description of Information to be Disclosed
(Patient/Client should check each item to be disclosed.)

☐ Diagnosis	☐ Dates of Treatment Only	☐ Insurance
☐ Treatment Plan	☐ Psychological Test Records	☐ Aftercare Treatment
☐ Progress Reports	☐ Court Order	☐ Other:_____
☐ Treatment Summary	☐ Educational/School Records	☐ Other:_____
☐ Family Involvement	☐ Legal Purposes	

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: _____

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to _____ at the above address. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

This release is in effect until _____unless otherwise specified.
(Date)

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

_____

Signature of Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual.

_____

Signature of Witness Date