Centre Psychology Group

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, DOB: _____ permit _____
(Name of Client) (CPG Therapist)

to receive information from ____ initials

to provide information to ____ initials

_____ Agency/Contact Info:_____
(Provider / Agency)

Date of services to be released: _____to _____

Type of treatment records requested/provided
( ) Mental Health
( ) HIV/AIDS
( ) Sexually Transmitted Diseases
( ) Drug and Alcohol Abuse
( ) General Medical Information
( ) MRI/CT (head)
( ) Medical Problem List / Current Medications

Specifically
( ) progress notes;
( ) treatment summary;
( ) psychological evaluation;
( ) other (specify) _____
( ) electronic communications (specify below)

Type of Electronic Communication _____

For the purpose of:
( ) developing a treatment plan;
( ) conducting an evaluation;
( ) treatment coordination;
( ) other (specify) _____

Expiration date: _____ (no later than one year from today) or under the following conditions:

_____

I understand that I may revoke this release at any time and that I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that authorizing the use or disclosure of the information identified above is voluntary. I understand that I do not need to sign this form to ensure healthcare treatment.
_____ (Initials and date)

Photocopy of release offered to client: ( ) received ( ) declined _____ Initials and date

_____ _____
Client's Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Witness Date

A photocopy of this authorization shall be considered as effective and valid as the original