**[INSERT PRACTICE NAME OR LOG HERE]**

**RELEASE OF INFORMATION**

Client Name (Last, first, middle initial)

Date of Birth Day Phone # Evening Phone #

**INFORMATION TO BE DISCLOSED TO AND FROM:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Address Phone

**AUTHORIZATION TO DISCLOSE MEDICAL / BILLING INFORMATION IS LIMITED TO THE FOLLOWING:**

Admission / Intake Summary Diagnosis & Treatment Plan Progress Notes Discharge Summary

Psychiatric Assessment Chemical Dependency Evaluation /Abuse/Drug/Alcohol Treatment  Psychological Assessment  Prior Treatment Records  Medication Management Records

Medical/Physical History Education Records Progress Review HIV History

Billing Records/Statements (date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THIS INFORMATION IS TO BE DISCLOSED FOR THE PURPOSE OF:**

Insurance Payment  Third Party Authorization and Payment  Communication regarding legal issues

Coordination of Care  Litigation Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. Please see your Notice of Privacy Practices for information on how to revoke this authorization. I also understand that this authorization will automatically expire one year from the date of my signature unless I revoke it earlier. Dr. Craig will not refuse or restrict my treatment if I choose not to sign this authorization. **A photocopy / fax of this authorization will be treated in the same manner as an original.**

Further, I realize that Dr. Craig cannot prevent the re-disclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore, Dr. Craig is released from any and all liability resulting from re-disclosure.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Dated