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AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____ Date of birth:_____ Age: ____ M F

Legal Guardian (if child): _____

I authorize the following provider and/or individuals to receive and release information from and to Elevate Counseling regarding the above-named client. Method of release shall be pertinent to treatment, assessment, or legal proceedings and may include photocopies, fax copies, personal review, audio, video, electronic or verbal communication.

Name: _____ Title:_____

Address: _____

Phone: _____ Email: _____

Name: _____ Title:_____

Address: _____

Phone: _____ Email: _____

Information to be received or released: *(Please check all that apply)*:

- Complete copy of medical record
- Intake information
- Treatment plan (s)
- Therapy notes
- Discharge summary
- Psychological evaluation

Conditions and Dates of Care Covered: All records to treatment termination or _____

Expiration or Revocation of Authorization: I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my previous revocation, this authorization will automatically end one year from date of signature or on _____.

Client/Guardian Signature: _____ Date: _____