Arise & Shine Counseling

Authorization for release of information

1. Client's Name:_____ DOB:_____

2. Information to be released : Summary of treatment to date Report Other:

_____

3. Purpose of Disclosure Coordination of Care

Other:_____

4. Persons authorized to make Disclosure:

_____

5. Person authorized to receive Disclosure:

_____

6. Method of Disclosure Written :

_____

Verbal:_____

Electronic: _____

7. Today's date: _____Authorization to expire on: _____

I understand that my health information is protected by law. I authorize the release of my confidential health information as indicated above. I understand that my consent is voluntary and I can revoke this permission at any time, except to the extent that it has already been shared based on this authorization. Should I choose to revoke this authorization I will state this in writing. Signature of

Patient:_____Date:_____

Signature of Personal Representative:_____