Know Thyself Healing & Therapy

Authorization for Release / Exchange of Information

Client Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

I Authorize: _____ to Receive and/or Release Information From/To:

Agency/Individual: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Information To Be Released/Shared Includes: ***(check all that apply)***

☐ All Records ☐ Ongoing Communication ☐ Diagnostic Report

☐ Testing Results ☐ Psychiatric Evaluation ☐ Treatment Plan

☐ Medical History ☐ School Records ☐ Family History

☐ Hospital Records ☐ Discharge Summary

☐ Other: _____

Information Will Be Released By: ***(check all that apply)***

☐ Telephone, ☐ Written, ☐ Un-Secure Email, ☐ Fax, ☐ In-Person

This Release Is Required For The Purposes Of: ***(check all that apply)***

☐ Continuation of Services ☐ Planning Appropriate Treatment ☐ Continue/Follow-Up Care

☐ Social Service Involvement ☐ Additional Care ☐ Other: _____

I understand that I may revoke this authorization at any time to the extent that action has been taken in reliance on it. I acknowledge that this authorization is voluntary and that payment or eligibility for benefits for my health care will not be affected if I do not sign this form. I also understand that the information disclosed as a result of this authorization may no longer be protected by privacy laws and may be disclosed by the company or individual receiving the information.

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____