Vienna Counseling

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____ Date: ____ / ____ / ____

I, _____, give my authorization for _____(Provider) to exchange information regarding my psychosocial evaluation, treatment history, medical history, and any other pertinent information for the purpose of collaborative care and coordinating services with:

_____

Contact Info:

This authorization will expire (please check ONLY ONE box):

- ❑ Upon the following date, event, or condition: _____
- ❑ Upon the completion/termination of treatment with the current provider.
- ❑ Other: _____

I understand that the duration of consent shall be consistent with the limitations identified above. I understand that after that specified expiration condition is met, no more information can be used or released to the person(s) or organization identified above unless a new Authorization of Release of Information form is signed.

I understand that I can revoke or cancel this Authorization for Release of Information at any time. If I do revoke this Authorization, it will prevent any release of information after the date it is received but cannot change the fact that some information may have been sent or shared prior to the date the Authorization was revoked

_____ _____

Signature of Client or Personal Representative Date

Request for prohibition of redisclosure: Information disclosed as permitted by this release is part of records for which confidentiality is protected. I request that you prohibit redisclosure of this information unless further disclosure is expressly permitted by the written authorization from the person to whom it pertains.

A photo copy of this completed release is considered to be as valid as the original document.