Bayside Neurotherapy

Authorization for Release of Information

Client(s) Information

Name: _____ Date of Birth: _____ / _____ / _____

Address:

_____

Street City State Zip

Contact Information:

_____

Home Phone Work Phone Email

Receiving Party

Name: _____ Relationship to Client(s):_____

Address:

_____

Street City State Zip

Contact Information:

_____

Phone Fax Email

Information to Be Released

___ Whether the client is in treatment or not
___ Prognosis (diagnosis, opinion of how treatment will benefit client, general peculiarities of case)
___ Nature of the services offered
___ Brief statement regarding progress
___ Other: _____

Purpose of the Release

___ Referral to other services
___ Coordination of care
___ Consultation with doctor
___ Consultation with other mental health provider
___ Transfer of care
___ Other: _____

Signature of Client and Therapist

This information lasts for one year after the date you sign it unless you enter a different date or expiration here: _____. This authorization may be canceled in writing at any time. Your signature indicates that you have read and understand this form and authorize release of your information as described above. You understand that you may refuse to sign this authorization and that refusal to sign will not affect treatment.

_____ _____ _____ _____

Client Signature Date Therapist Signature Date