Authorization to Exchange, Obtain, or Release Information

Client Name: _____ Date of Birth: _____

Home Address: _____

_____

For the reasons identified in this form, I _____ (client or guardian) hereby grant The Center for Connection permission to communicate (exchange, obtain, or release) my protected health information with the following person(s) or agency(ies):

1. Name of Person/Agency: _____
Person/Agency address, telephone, and email: _____
_____
_____

Information to Be Shared: (check all that apply)
☐ Medical history/developmental history ☐ Exchange ☐ Obtain ☐ Release
☐ Evaluation/assessment findings ☐ Exchange ☐ Obtain ☐ Release
☐ Treatment information ☐ Exchange ☐ Obtain ☐ Release
☐ Academic records ☐ Exchange ☐ Obtain ☐ Release
☐ Other: _____ ☐ Exchange ☐ Obtain ☐ Release

I grant permission to exchange information via:
☐ Written communication (mailed report, email, etc.)
☐ Phone call
☐ In-person or virtual meeting

_____

2. Name of Person/Agency: _____

Person/Agency address, telephone, and email: _____
_____
_____

Information to Be Shared: (check all that apply)
☐ Medical history/developmental history ☐ Exchange ☐ Obtain ☐ Release

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☐ Evaluation/assessment findings ☐ Exchange ☐ Obtain ☐ Release
☐ Treatment information ☐ Exchange ☐ Obtain ☐ Release
☐ Academic records ☐ Exchange ☐ Obtain ☐ Release
☐ Other: _____ ☐ Exchange ☐ Obtain ☐ Release

I grant permission to exchange information via:
☐ Written communication (mailed report, email, etc.)
☐ Phone call
☐ In-person or virtual meeting

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3. Name of Person/Agency: _____

Person/Agency address, telephone, and email: _____
_____
_____

Information to Be Shared: (check all that apply)
☐ Medical history/developmental history ☐ Exchange ☐ Obtain ☐ Release
☐ Evaluation/assessment findings ☐ Exchange ☐ Obtain ☐ Release
☐ Treatment information ☐ Exchange ☐ Obtain ☐ Release
☐ Academic records ☐ Exchange ☐ Obtain ☐ Release
☐ Other: _____ ☐ Exchange ☐ Obtain ☐ Release

I grant permission to exchange information via:
☐ Written communication (mailed report, email, etc.)
☐ Phone call
☐ In-person or virtual meeting

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4. Name of Person/Agency: _____

Person/Agency address, telephone, and email: _____
_____
_____

Information to Be Shared: (check all that apply)
☐ Medical history/developmental history ☐ Exchange ☐ Obtain ☐ Release

Authorization to Exchange, Obtain, or Release Information

☐ Evaluation/assessment findings ☐ Exchange ☐ Obtain ☐ Release
☐ Treatment information ☐ Exchange ☐ Obtain ☐ Release
☐ Academic records ☐ Exchange ☐ Obtain ☐ Release
☐ Other: _____ ☐ Exchange ☐ Obtain ☐ Release

I grant permission to exchange information via:
☐ Written communication (mailed report, email, etc.)
☐ Phone call
☐ In-person or virtual meeting

ACKNOWLEDGMENT AND CONSENT
Your signature provided below or electronically via our therapy notes web portal indicates that you have read and understood the information provided here and that you agree to these terms (either for yourself or your minor child). I also understand that this authorization will remain valid for 12 moths or until written revocation of this authorization is presented, whichever comes first.

_____ _____
Print Name of Client Date

_____ _____
Signature of Client/Guardian Relationship to Client