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Release of Information

I, ______________________________[Insert Name of Patient/Client], whose Date of Birth is ______,

authorize Anne Rafal Counseling to disclose to and/or obtain from:

____ the following information:
[Insert Name of Person or Title of Person or Organization]

Description of Information to be Disclosed: (Patient/Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to [Insert Name] at [Insert Contact Information]. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this authorization expires on the following date: ________________ or as otherwise indicated:____

I will be given a copy of this authorization for my records.

____
Signature of Patient/Client Date

____
Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____Check here if patient/client refuses to sign authorization

____
Signature of Staff Witness Date