Authorization for Release of Confidential Information

I, _____, authorize Independent Practitioner, _____,
Client's Name **Therapist's Name**
at Daylily Health, to [release], [request], and/or [share] (circle all that apply) confidential medical record information [to],

[from], [with] (circle all that apply), _____.
Person or Place to Exchange Information
Phone: _____ Fax: _____

The information shall consist of: Duplicate records/verbal consultation concerning treatment and/or education.

Specify:

	All Clinical Records		Psychological Evaluation		Treatment Compliance
	Medical History		Social History		Discharge Summary
	Mental Health Info		Master Treatment Plan		Psychiatric Evaluation
	PCP Contact		Drug/Alcohol test/results		Drug/Alcohol diagnosis, treatment, referral info.
	Emergency Contact		Scheduling		Billing/Payments

The information is needed for the purpose of adopting a more comprehensive and integrated approach to my health care and maintaining a continuity of care for this purpose only unless otherwise permitted or required by law.

This authorization may be revoked at any time by the client. Revoking of this authorization shall not cancel any prior action that has already transpired. If not revoked, it shall terminate the last day of the clinical treatment.

A photocopy, facsimile, or duplicate copy of this authorization shall be as valid as the original.

The person signing this consent has a right to receive a copy of it. My initials, _____, indicate that I have received a copy of this authorization to release medical records.

I have read and understood the nature of this release. I understand that I may revoke it at any time. I release the director, therapists, employees and the above-named organizations from any liability that may arise from this action whether or not foreseen at present. I understand that certain medical records (including any alcohol and drug abuse information**) may be protected by Federal Regulations. **Drug Abuse Office and Treatment Act of 1972 21 U.S.C. 1175; Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 U.S.C. 4582).

_____ _____ _____ _____
Signature of Client **Date** **Witness** **Date**

_____ _____ _____
Signature of Legal Representative (minor or incapacitated) **Relationship to Client** **Date**

☐ **I do not give my mental health provider permission to contact my primary care physician therapist or another type of provider.**