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RELEASE OF INFORMATION

Client Name:	**DOB:**
SSN:	**Phone:**
Address:	**City, State, Zip:**

I, _____, hereby authorize the release and exchange of information specified below between:

Name Relationship to Client

Organization/Address

Phone/Fax

This release of information shall be limited to the following specific types of information:

____ Assessment
____ Diagnosis
____ Psychosocial Information
____ Psychological Evaluation
____ Treatment Plan or Summary
____ Current Treatment Update
____ Presence/Participation in Treatment
____ Other _____
____ ____ Educational Information

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: _____

This authorization for release of information is made with informed consent, and this consent is subject to revocation by written instructions of the undersigned at any time by sending notification to Rachel Eddins in writing. However, a revocation is not valid to the extent that parties have acted in reliance on such authorization. The information is confidential and any redisclosure by the recipient is prohibited, unless expressly permitted by the patient or someone authorized to act on his/her behalf. I understand that this authorization authorizes the release of all medical records including Psychiatric, Alcohol, Drug Abuse, and AIDS records. This release is valid for (1) one year and must be renewed after 365 days.

Client Name (Printed)

Client Signature Date