Authorization For Exchange of Information

I, the parent/legal guardian of _____[First and last Name of Patient/Client], authorize_____ [Organization/Person] to disclose to and/or obtain relevant information from_____ [Person/Organization].

Purpose

The purpose of this disclosure of information is to improve treatment planning, share information relevant to treatment, and, when appropriate, coordinate treatment services.

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].

Expiration

Unless sooner revoked, this authorization expires in one year on the following date: _____.

Forms of Disclosure

I agree to allow disclosure in any manner that is appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

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

_____

Signature of Parent/Guardian

Date

_____Check here if Parent/Guardian refuses to sign authorization

_____

Signature of Staff Witness Date