
Authorization For Release of Information

I authorize _____ to release
(Therapist/Facility)

(State specific nature of information to be disclosed)

about _____ to
(Client's name)

(Receiving person and institution/agency/organization)

(Address)

for the purpose of

This consent is valid until _____

I understand that I may revoke this consent at any time and that the above-named person authorized to receive this information has the right to inspect and copy the information to be disclosed.

It has been explained to me that if I refuse to consent to the release of information, the following are the consequences (specify, if any):

(Signature)

(Witness)

(Date)

(Date)