



Authorization for Release of Information for Referring Practice:

CONFIDENTIAL

Regarding: _____ DOB: _____

I consent to allow 3-C Family Services to release and/or exchange information with:

Name of Persons/Agency: _____

Complete Address: _____

Telephone/Fax Number: _____

This information will include:

- | | | |
|--|---|---|
| <input type="checkbox"/> Psychiatric Records | <input type="checkbox"/> Testing | <input type="checkbox"/> Behavioral Observations/Checklists |
| <input type="checkbox"/> Therapy Notes | <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Laboratory Work |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> All of the Above | |

Other _____

Specific Purpose: _____

This authorization shall remain in effect for one year, ending ____/____/____ .

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of securing insurance coverage and the insurer has a legal right to contest a claim.

Should you wish us to take any additional action regarding this release of information, please send a separate letter regarding this request.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

Signature of Patient

Date

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.

This is strictly a confidential patient medical record. Redisclosure or transfer is expressly prohibited by law. (rev. YSE 8.25.11)