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AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____

Date of Birth: _____

Address: _____

City:_____ State: _____ Zip Code: _____

I authorize _____ (Clinician Name) at The Willow Partnership to exchange information regarding the above named individual as described below.

The type of information to be exchanged is as follows:

_____

This information may be exchanged with the following individual or organization:

Name:_____

Address/Phone:_____

_____

I understand that I have a right to revoke this authorization at any time. My revocation becomes effective when delivered in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire at the end of treatment, unless an expiration date, event or condition is specified as follows:

_____

_____

Name of Client, Parent, or Legal Guardian

_____ _____

Signature of Client, Parent, or Legal Guardian Date