Compassion Clinic: Therapy Services
Authorization for Release of Confidential Information

PLEASE RETURN INFORMATION TO THE ATTENTION OF: **Tyler Rekowski**

I,_____ authorize Compassion Clinic: Therapy Services to:

- □ Disclose information to:
- □ obtain information from:
- □ Exchange information with:

_____

(Name of Person) **(Name of Agency)**

_____

(Address)

_____

(City) **(State)** **(Zip)**

_____

Fax # **Phone #**

Regarding: □ Myself

□ other: _____

(Name) **(Date of Birth)**

_____

(Address)

The information to be disclosed is:

- □ Discharge/treatment summary
- □ Progress notes/Consulting
- □ Academic records/school functioning
- □ Psychological testing
- □ Social/Court Services Summary
- □ Other: _____
- □ Admission/Intake Summary
- □ Diagnostic Impressions
- □ Chemical Dependency Evaluation
- □ Medical history & physical exam
- □ Medication history

The purpose of this disclosure is: Coordination and/or Transfer of Care

I understand that my records are protected by the Data Privacy regulations and cannot be disclosed without written consent unless otherwise provided for in the regulations, and that I may revoke the consent at any time. I understand that this consent will automatically expire without my express revocation upon fulfillment of the above stated purpose or one year from this date, whichever is sooner. I have the right to receive a copy or review information to be disclosed, if requested.

_____

Signature of client or (if minor) parent/guardian **Date**