Bayside Neurotherapy

Authorization for Release of Information

Client Information

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Work Phone: _____ Email: _____

Receiving Party Information

Name: _____ Relationship to Client(s): _____

Address: _____

Phone: _____ Fax: _____ Email: _____

Information to Be Released

- ☐ Whether the client is in treatment or not.
- ☐ Prognosis (diagnosis, opinion of how treatment will benefit client, general peculiarities of case).
- ☐ Nature of the services offered.
- ☐ Brief statement regarding progress.
- ☐ Other: _____

Purpose of the Release

- ☐ Referral to other services.
- ☐ Coordination of care.
- ☐ Consultation with doctor.
- ☐ Consultation with other mental health provider.
- ☐ Transfer of care.
- ☐ Other: _____

Signature of Client and Therapist

This information lasts for one year after the date you sign it unless you enter a different date or expiration here: _____. This authorization may be canceled in writing at any time. Your signature indicates that you have read and understand this form and authorize release of your information as described above. You understand that you may refuse to sign this authorization and that refusal to sign will not affect treatment.

_____	_____	_____	_____
Client Signature	Date	Therapist Signature	Date