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Authorization for the Release or Exchange of Information

Patient Name: ________________________________ Date of Birth: _______________________

Information to be released or exchanged with:

Name: ____

Address: ____

Information to be released by or exchanged:

_____ History and Physical Exam
_____ Discharge Summary
_____ Psychiatric Evaluation
_____ Psychological Test Results
_____ Chemical Recovery History
_____ Dates of Hospitalization
_____ Crisis Intervention Reports
_____ Family Systems Evaluation
_____ Consultation Reports
_____ Educational Tests & Reports
_____ Psychosocial Report
_____ Court/Agency Documents
_____ Mental Status
_____ Treatment Plans
_____ Progress/Case Notes
_____ Therapists Orders
_____ Diagnosis
_____ Medical Records
_____ Nursing Notes
_____ Educational Records
_____ Attendance Record
_____ Lab Results

Other (Specify) ____
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____ _________________________
Patient Signature Date