Authorization for Release of Information

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By signing this form, confidential information can be released to and/or discussed with the people or agencies listed below unless noted by exceptions or limitations. This form is signed voluntarily and at any time changes can be made by the person named as the client on this form. This form also represents a **reciprocal release form**. By signing this form, Paul Duke has permission to release information to the Receiving Party listed below, AND the Receiving Party has permission to release information to Paul Duke.

Client's Name: ____ DOB:____________________

Information to be released:
☐ Relevant Treatment Information ☐ Other: ____

☐ Exclusions or limitations:____

Purpose of Disclosure
☐ Coordination of Care ☐ Other: ____

Receiving Party of this **Release of Information**:

Name: __________________________________ Phone:______________________________________

Name: __________________________________ Phone:______________________________________

Name: __________________________________ Phone:______________________________________

Name: __________________________________ Phone:______________________________________

Method of Disclosure
☐ Written ☐ Verbal ☐ Electronic

I understand that my health information is protected by law. I authorize the release of my confidential health information as indicated above. I understand that my consent is voluntary and I can revoke this permission at any time, except to the extent that it has already been shared based on this authorization. Should I choose to revoke this authorization I will state this in writing.

Signature of Client: ____ Date:________________

Signature of Parent: ____ Date:________________
(for clients under 13)

Authorized representative: ____ Date:________________
(if client is unable to represent themselves for any reason)