AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION TO FAMILY MEMBERS

Name of client: _____

Date of birth: _____

I understand the release of treatment information and communication with important individuals in _____'s (*client's name*) life will be used for the sole purpose of improving treatment.

To further this goal, I authorize _____ (*clinic/therapist*) to release the information specified below regarding me/the client to the individual(s) listed below. I also authorize the professional to obtain information from my/the client's family. This authorization form will expire 90 days from the date it was signed, unless the client lists a specific date below.

The information to be disclosed is indicated by an "X" in the applicable boxes:

☐ Names of professionals
☐ Treatment plan
☐ Admission and/or discharge information
☐ Psychological evaluations
☐ Medications
☐ Treatment notes/summary
☐ Other:_____

This information is to be disclosed to these persons, who have indicated their relationship to me/the client. Confidentiality and privacy have been reviewed with me, and I fully understand the risks.

_____	_____	_____
(Name)	(Relationship)	(Phone number)
_____	_____	_____
(Name)	(Relationship)	(Phone number)
_____	_____	_____
(Name)	(Relationship)	(Phone number)

Client's Signature: _____ Date: _____

This form will expire 90 days from the signed date, unless otherwise indicated.
Alternative Expiration Date: _____