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Release of Information of Protected Health Insurance

I, _____, authorize _____ to:
____ (send) ____ (receive) the following ____ (to) ____ (from) the following agencies or people:

Name: _____
Address: _____ City: _____ State: _____ Zip: _____

Name: _____
Address: _____ City: _____ State: _____ Zip: _____

Name: _____
Address: _____ City: _____ State: _____ Zip: _____

___	Academic testing results	___	Psychological testing results
___	Behavior programs	___	Service plans
___	Case notes	___	Summary reports
___	Intelligence testing results	___	Vocational testing results
___	Medical records	___	Entire record
___	Personality profiles	___	Other (specify) _____
___	Progress notes		_____
___	Psychological reports		_____

The above information will be used for the following purposes:

___ Planning appropriate treatment or program
___ Continuing appropriate treatment or program
___ Determining eligibility for benefits or program
___ Case review
___ Updating files
___ Other (specify) _____

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

Client's signature: _____ Date: ___/___/___
Parent/guardian signature: _____ Date: ___/___/___
Witness (if client is unable to sign): _____ Date: ___/___/___
Person informing client of rights: _____ Date: ___/___/___
Mail to: _____ Address: _____