Release of Confidential Information

Patient: ____

Date: ____

I ____ **hereby authorize (clinician)** ______________________________ **to disclose**

( )Information about my treatment ( )medical record ( ) ____

This information is to be released to: ____

____ ____________________________

I hereby authorize (clinician) ___________________________________ **to obtain psychological/health information from**

(outside clinician)____ ______________________

I hereby release (clinician) ___________________________ **from any liability that may result from the release of confidential information or which may arise as a result from the use of this information contained in the records released. This content is subject to revocation by the undersigned at any time except to the extent that action has already been taken.**

This consent is valid for to (2) years from the date below.

_______________________________________ _____________________________________ ______________________

Patient name **Signature** **Date**