# Authorization for Release of Information

1. Client Name:_____ DOB:_____

2. Information to be released (check and describe)

___ Summary of treatment to date
___ Report
___ Other: _____

_____

3. Purpose of Disclosure (check and describe)

___ Coordination of Care
___ Other:_____

_____

4. Persons Authorized to Make Disclosure: _____

5. Person Authorized to Receive Disclosure: _____

6. Method of Disclosure (check and describe)

___ Written: _____
___ Verbal: _____
___ Electronic: _____

7. Today's date: _____ Authorization to expire on _____

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.

Client Signature _____Date _____

Parent/Guardian Name (if applicable) _____

Parent/Guardian Signature _____Date _____

Mindful Counseling Center, 3069 English Creek Ave., Suite 224, Egg Harbor Township, New Jersey 08234

Phone (609) 377-5859
Fax: 609-573-5433

E-mail: info@mindful-counseling-center.com
Website: mindful-counseling-center.com