Authorization for Release of Confidential Information

Entity Releasing Information:

_____

_____

_____

Entity Receiving Information:

_____

_____

_____

Purpose for Release of Information:

☐ Diagnosis and Treatment Planning ☐ Collaboration ☐ Other: _____

Information to be released:

☐ Diagnostic Assessment ☐ School Records ☐ Attendance/Program Enrollment

☐ Treatment Summary ☐ Medical Records ☐ Drug/Alcohol Assessment/Screening

☐ Legal Information ☐ Referral Information ☐ Discharge Summary/Instructions

Client Consent:

I, (client or guardian name) _____, hereby authorize **Positive Pathways, LLC**, its employees and agents, to release my personal health information (e.g. information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, member ID number, except the following information:

_____

_____

I understand that I can revoke this authorization at any time without penalty. I understand that I have the right to a copy of this authorization. I understand that this authorization is voluntary and that I may refuse to sign. My refusal to sign will not affect my eligibility for services or benefits.

Name (Printed): _____

Signature: _____ **Date:** _____

Therapist Signature: _____ Date: _____

I HEREBY *REVOKE* MY AUTHORIZATION TO RELEASE INFORMATION, AS INDICATED BY MY SIGNATURE BELOW:

Signature: _____ Date: _____