to bear witness
THERAPY

Authorization for Release of Information

This form, when completed and signed by you, authorizes me to release or receive protected information concerning your clinical records from or to the person you designate.

Client's name: _____Date of Birth: ___/___/___

Date authorization initiated: ___/___/__

I authorize To Bear Witness to ☐ release information and/or ☐ receive information to and/or from:
Name _____

Address _____

Phone Number: _____

Information Authorized (please initial):
_____ treatment summary _____ psychosocial assessment/intake
_____ diagnosis _____ dates of treatment attendance
_____ other (specify) _____
for the purpose of (please initial):
_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____
I further authorize that this disclosure ***will*** include information relating to (please initial):
_____Assessment/treatment for alcohol and/or drug abuse
_____Behavioral health services/psychiatric care
_____HIV/AIDS

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____.
I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____
Signature of Client Date

_____
Signature of Witness Date