Ahh Therapy
Achieving Harmony and Health

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's Name: _____ DOB: _____

Information to be released:

- ☐ Summary of treatment to date
- ☐ Report
- ☐ Other: _____

Purpose of Disclosure:

- ☐ Coordination of Care
- ☐ Other: _____

Persons authorized to make Disclosure: _____

Person authorized to receive Disclosure: _____

Method of Disclosure:

- ☐ Written : _____
- ☐ Verbal: _____
- ☐ Electronic: _____

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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.

Signature of Client:_____ Date : _____

Signature of Personal Representative:_____ Date: _____