Authorization to Release – Exchange Confidential Information

I, (Print Name of Client)____hereby authorize ***Umbrellex Behavioral Health Services, LLC*** to release – exchange confidential information obtained during the course of my treatment with *(List name or entities to which information is to be released - exchanged):*_______________________________________

This Authorization permits the release – exchange of the following information:

☐ Social History/Intake ☐ Treatment Plan ☐ Prognosis

☐ Diagnosis ☐ Progress to date ☐ Psychological test results

☐ Dates of Treatment ☐ Patient records ☐ Medication History

☐ Other: ____
____

I authorize the release – exchange of information described above for the following purposes:
____
____

The recipient may use the information described above for the following purposes: _________
____

I understand that I have the right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This authorization shall remain valid while client is in treatment and/or specialized residential settings, and up to one year after treatment and/or placement ends. A copy is as valid as the original. I authorize that this form may be faxed if necessary. I authorize Umbrellex Behavioral Health Services to keep my referring party updated through mailing, e-mailing, and / or Faxing updates / reports.

By:____ Date: _____________
(Client or Client's Representative)

Witnessed:_________________________________ Date: _____________
(Agency Representative)

If signed by other than Client – please indicate the relationship between Client and his / her Representative. ____

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