ELITE CENTER FOR CHANGE

Consent for Release of Information

Client Name: _____

I hereby authorize Elite Center for Change to use or disclose my protected health information as indicated below to:

Name/Organization: _____

Relationship **:☐ Parent or guardian ☐ Spouse ☐Doctor ☐ other**_____

Address: _____

_____

Phone _____ **Fax:**_____

Information is to be disclosed: _____ verbally _____ In writing

Information to be released:

____ Dates of service _____ Assessment/Progress Notes

_____ Medical Information _____ Treatment Recommendations _____ Other

The purpose/need for this disclosure: _____ Continuity of Care _____ Legal

_____ Request of individual Other_____

1. I understand that this authorization will expire one year from my last date of service. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time in writing.
3. My health care and payment for my health care will not be affected, if I do not sign this form.

Authorization and Signature: I authorize the release of my confidential protected health information. I understand that this authorization is voluntary, and that the information to be disclosed is protected by law. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use/or disclosure of my confidential protected health information.

X_____DOB:_____ Date:_____

Signature of Client or Guardian/Parent

Notice to party receiving information. This Information has been disclosed to you from records whose confidentiality is protected by Federal Laws which prohibit you from making any further disclosure of information without the specific written consent of the person to whom it pertains.