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TWO-WAY AUTHORIZATION TO RELEASE INFORMATION

I, _____, for _____ authorize
(Parent/Guardian) (Client Name)
my therapist, _____, **to release information to AND exchange**

information with :

_____
(Name of person/organization/agency)

_____
(Mailing address)

_____
(Fax/phone number)

I authorize the release/disclosure of the following information from the client's record:
_____any/all information, including verbal consultation regarding treatment
_____medical record: (specify) _____
_____complete academic record, including report cards, proficiency and academic testing, IEP, MFE, and any other applicable information
_____psychosocial history
_____treatment plan
_____diagnosis/assessment
_____treatment or discharge summary
_____psychological evaluation
_____treatment/progress notes

I understand that the release of the above information is for the following purpose:

This authorization will remain in effect until:
_____90 days after the date signed below
_____180 days after the date signed below
_____the date of discharge from treatment with therapist listed above.

I understand that I have the right to revoke this authorization, in writing, at any time, but that my revocation will not be effective to the extent that my therapist has already taken action in reliance on this authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my therapist generally may not condition psychotherapy services upon my signing an authorization unless the psychotherapy services are provided to me for the purpose of creating health information for a third party.

_____ _____ _____
(Signature of Client/Parent/Guardian) (Date) (Client's Date of Birth)

_____ _____
(Relationship to Client) (Signature of Witness)