Beech Tree
Consulting &
Psychological Services

Authorization to Release/Exchange Confidential Information

↗Name of Patient Date of Birth

I understand that the purpose of this release is to assist with my/this patient's treatment by improving communication between professional service providers or agencies. To further this goal, I authorize ___________________ to release the specified information regarding me/the patient to the individual(s) listed below, and to receive information from them. I have been informed of the risks to privacy and limitations on confidentiality inherent in the use of electronic means of information transfer, and I accept these.

The information to be disclosed is marked by an X in the boxes below.
Any items not to be released have a line drawn through them.

- ❑ Name of therapist
- ❑ Name of case manager
- ❑ Name(s) of treatment program(s)
- ❑ Treatment plan
- ❑ Progress notes
- ❑ Admission/discharge information
- ❑ Discharge plans
- ❑ Scheduled appointments
- ❑ Compliance with treatment
- ❑ Treatment summary
- ❑ Psychological evaluation
- ❑ Medications
- ❑ Other:

This information is to be disclosed to these persons who have the indicated relationship to me/the patient:

↗ Name of person Relationship

↗ Address

↗ Phone Fax E-mail

6249 South East Street, Suite I
Indianapolis, Indiana 46227

317 780 5750 phone
317 780 5755 fax

beechtreepsych.com

I understand that I may revoke this release at any time, except to the extent it has already been acted on. This release will expire:

❑ one year from this date

❑ on my discharge from treatment by this agency or by the person specified above

❑ under these circumstances: ______________________________

____

↗ Signature of client | Printed name | Date

____

↗ Signature of parent/guardian/representative | Printed name | Relationship | Date

I witnessed that the person understood the nature of this request/authorization and freely gave his or her consent.

____

↗ Signature of witness | Printed name | Date

❑ Copy for patient or parent/guardian

❑ Copy for provider/therapist/case manager