insight
Therapy Group

Authorization to Release Information

Please neatly PRINT (except signature) and provide complete information in each section

Client's Legal Name: _____ Birth Date: _____

By signing this form, I am allowing Insight Therapy Group to release medical information concerning the above named client to the person or facility listed below.

_____

Name of Person and/or Institution who will receive information

_____

Complete mailing address/street/PO Box City, State, Zip Code

_____

Phone Number Fax Number Email

Specific records authorized for release:

____ Discharge Summary ____ Diagnosis/Client History ____ Progress Notes

____ Treatment Plans ____ Assessment/Evaluation

Unless specified below under "Limitations," this authorization includes written and verbal disclosures and electronic interchange.

____ *Limitations (please specify)* _____

_____

Affirmation of Release

I give the above name agency permission to release only the information I have selected on this form to the individual(s) or entities I have named. I understand that this release is valid for **one year** from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time.

Any revocation or refusal to sign this authorization will not affect my ability to obtain health care services. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records during hospitalization and after discharge. Copies of the records may be obtained by me with reasonable notice and payment of copying costs. I understand that if the person or entity that receives the above specified information is not a health care provider, health plan, or health clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be re-disclosed and no longer protected by the regulations. I further understand that the Recipient WITHOUT FURTHER AUTHORIZATION, re-disclose said information to parties and their legal counsel, insurers, reinsurers, experts, potential experts, anyone against whom a claim has been made, administrative agency and court officials hearing the claim, and any agents, employees, or representatives of any said persons. A copy of this authorization shall be deemed the same as the original.

I understand that the information may be released electronically, and may include information in the following categories:

____ Mental Health ____ Substance Abuse ____ HIV-related information

_____ _____

Signature of Identified Client/Parent/Legal Guardian Date

_____

If signature is not that of the client's, indicate relationship to the client

_____

Witness Signature

Copy of Authorization to Release Information: ☐ Provided ☐ Refused