Authorization for Release of Information

Name: _____ **Date of Birth:** _____

Address: _____ **City, State, Zip:** _____

Phone Number: _____

☐ **I authorize Greenhouse Therapy to release information to:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (Include area code)

☐ **I authorize Greenhouse Therapy to obtain information from:**

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone #/Fax # (Include area code)

TYPE OF RECORDS AUTHORIZED: ☐ **Assessment and Update Reports**
☐ **Information in regards to progress/techniques being used**

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

☐ **Assessments** ☐ **Progress Notes** ☐ **Diagnostic Impression** ☐ **Discharge Summary**
☐ **Treatment Summary** ☐ **Treatment Plans**

☐ **Other: (**please describe)_____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.

My authorization will expire:
☐ When I am no longer receiving services from the Greenhouse Therapy.
☐ One year from this date. ☐ Other: _____

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a ***written*** request to Greenhouse Therapy.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.

Signature of Client or Guardian: _____ Date: _____

Relationship to Client: ☐ Parent ☐ Legal Guardian ☐ Other: _____