MetPsych

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Metrolina Psychotherapy Associates, P.A.

Authorization for Release / Exchange of Information

Client Name: _____ Date of Birth: _____Today's Date: _____
I _____, do hereby authorize the ____release ____ exchange
(Client Name or Guardian)

of the following information, including Psychiatric, Psychological and Substance abuse information unless checked below:

___ Initial Assessment ___ Progress Notes from _____ to _____

___ Attendance, Compliance and Progress in Treatment ___ Treatment Plan

Others: ___Laboratory Reports ___Admission summary ___Billing Information ___Medication

___ Discharge Summary ___ Drug Screens/Breathalyzer Results ___ Psychological Testing

___ Do Not	Authorize release of information related to AIDS (Acquired Immunodeficiency Syndrome) of HIV (Human Immunodeficiency Virus) Infection, psychiatric care and/or psychological assessment and treatment For alcohol and/or drug abuse.

*****Information to be released to***:** *****or received from***:**

_____ _____
Name of Company/ Agency / Facility / Person Name of Company/ Agency / Facility / Person

_____ ___ _____

_____ ___ _____

_____ _____ _____ _____
Phone Fax Phone Fax

Purpose of Disclosure:

___ Coordination of Care ___ Change of Doctor / Clinician ___Insurance/Medical Billing
___ Legal Investigation ___ Disability Determination ___ Workers Comp
___ Referral ___ Personal ___ Other: _____

I understand that I may revoke my authorization at any time to the extent that the agency which is to release information has already acted in the reliance on it. If not revoked sooner, this authorization will expire upon _____ (date not to exceed one year) or when the following event or condition occurs: _____.

_____ _____
Signature of Client or Guardian Date