Authorization For Release/Exchange of Information

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(520) 477-2273 CARE@Dr-Courtney.com

I, (parent/guardian, if client is a minor)_____, hereby authorize Dr. Courtney Schuneman to obtain information from and release information to (name, address, phone, email, etc.):

_____

_____

I understand that this release/exchange pertains to:

Client: _____Date of Birth: _____

I understand that the purpose of this release is to improve assessment/treatment planning, share information relevant to treatment and, when appropriate, coordinate treatment services. If there is another purpose please specify:

_____

I understand that the portion(s) of the record to be released include:

( ) All
( ) Diagnostic Evaluation
( ) Summary of Contact with Client
( ) Diagnostic Test Reports
( ) Verbal Contact
( ) Other:_____

I have discussed with Dr. Schuneman the issues concerning privacy and confidentiality, and I agree to the reasons for this exchange of information. I understand that photocopies of this form are considered as valid as the original. I am also satisfied that confidentiality will be upheld and understand that this authorization will remain in effect until:

_____ Treatment with Dr. Schuneman is terminated

_____ Specify Date: _____ (usually no more than one year)

I understand that I have the right to revoke consent to future disclosure in writing at any time; this precludes disclosures that have already been made in reliance upon my prior consent. I understand that I have the right to inspect and copy the information to be disclosed. I will be given a copy of this authorization for my records upon request.

_____

Signature of Client *Client Name* *Date*

_____

Signature of Guardian *Guardian Name* *Date*

_____

Signature of Staff Witness Name *Staff Witness Printed Name* *Date*