INTEGRATED
treatment solutions

Authorization to Release Confidential Information

Name of client: _____ Date of Birth: _____

I understand that the purpose of this release is to manage my case and support my treatment/ program participation by improving communication between professional service providers or agencies. To further this goal, I authorize Integrated Treatment Solutions, to release the specified information below regarding my clinical status, needs and participation in services. I also authorize Integrated Treatment Solutions to receive information from such service providers.

I have been informed of the risks to privacy and limitations on confidentiality of the use of electronic means of information transfer which may be utilized, and I accept these.

The information to be disclosed is marked by an "✔" in the boxes below, and any items not to be released have a line drawn through them:

❑ Name of Provider and specialty: _____

❑ Phone and fax numbers: _____

❑ Name of Case Manager and organization: _____

❑ Phone and fax numbers : _____

❑ Other Providers, Referral Sources or Attorney : _____

_____

❑ Phone and fax numbers : _____

❑ Name(s) of treatment program(s) : _____

❑ Admission/discharge information ❑ Treatment plan ❑ Scheduled appointments

❑ Progress notes ❑ Compliance with treatment ❑ Discharge plans

❑ Treatment summary ❑ Psychological evaluation ❑ Medications

❑ Other: _____

I understand that I may revoke this release at any time, except to the extent that it has already been acted upon. This release will expire upon my discharge from treatment by this agency, or under these circumstances:

_____

Signature of client

_____

Printed name Date