NEUROBLOOM
PSYCHOLOGICAL CLINIC

Authorization for Release of Information

1. Client's Name:_____ DOB:_____

2. Information to be released :
   - ☐ Summary of treatment to
   - ☐ date Report
   - ☐ Other: _____

3. Purpose of Disclosure
   - ☐ Coordination of Care
   - ☐ Other:_____

4. Persons authorized to make Disclosure:

   _____

5. Person authorized to receive Disclosure:

   _____

6. Method of Disclosure
   - ☐ Written :
   - ☐ _____
   - ☐ Verbal:

     _____

     Electronic: _____

7. Today's date:_____Authorization to expire on: _____

I understand that my health information is protected by law. I authorize the release of my confidential health information as indicated above. I understand that my consent is voluntary and I can revoke this permission at any time, except to the extent that it has already been shared based on this authorization. Should I choose to revoke this authorization I will state this in writing.

Signature of Patient:_____ Date:_____

Signature of Personal Representative:_____