Irving & Associates in Behavioral Health
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AUTHORIZATION TO RELEASE INFORMATION

Patient Name: ______________________________

Date of Birth: ________/________/____________

If you use Medicare (National Government Services) as your insurance provider, please list your social security number below:

_______________-___________-_____________

I/We authorize and request (therapist's name) ____

release of my confidential and professional information; including personal, psychiatric, medical, laboratory, psychological testing data and interpretations, social, educational, substance abuse, clinical information, opinions, and/or any other information regarding contacts with myself to:

Name: ____________________________________

Fax: (________) ___________-________________

Phone: (________) _________-________________

Address: __________________________________

City: _____________________________________

State/Zip: _________________________________

Effective dates: _______/_______/______ to ______/______/______

I/We understand that my refusal to consent to release information specified above will prevent disclosure of such materials to the person/facilities named herein, with the potential consequence of reduced accuracy and completeness of my case.

This release is valid from _______/_______/_______ through _______/_______/_______, unless otherwise noted.

____
Print Name of Client

____
Signature of Client

____
Signature of Parent/Legal Guardian if the client is under the age of 18

____
Date

Witness signature: ____