**AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION**

|  |  |  |  |
| --- | --- | --- | --- |
| Patient Name: |  | Date of Birth: |  |

I hereby authorize the mutual release and/or exchange of information as indicated below, in order for my clinician to appropriately communicate with other individuals outside of the Anxiety & OCD Behavioral Health Center:

**Communication with allied health professional:** consultation on assessment results, diagnoses, medication, and treatment; coordination and implementation of treatment/behavioral plan

**Communication with school:** psychoeducation about disorder(s); sharing of child’s relevant academic and behavioral information; coordination and implementation of treatment/behavioral plan; consultation on 504 plan/IEP

**Communication with parents/guardian/guarantor (patients 18 and older only):** payments; homework and treatment compliance; attendance; lateness; termination; referral

**Communication with parents/guardian/guarantor (patients 18 and older only):** Coordination and implementation of treatment/behavioral plan

**Emergency contact:** person to be contacted in case of emergency

**Other:**

**Restrictions:**

Mutual information exchange via email, voicemail, and phone calls between one of the clinicians at the Anxiety & OCD Behavioral Health Center, and the follow party(ies):

|  |  |  |  |
| --- | --- | --- | --- |
| To/From: |  | To/From: |  |

|  |  |
| --- | --- |
| Title/Agency: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone Number: |  | Fax: |  |

|  |  |
| --- | --- |
| Email: |  |

I hold harmless the Anxiety & OCD Behavioral Health Center in regard to the use of information authorized for release or exchange. This release expires exactly one year after this release has been signed or at the discretion of the signed party. I have the right to cancel this release at any time. However, cancellation does not affect past action.

|  |  |  |  |
| --- | --- | --- | --- |
| PATIENT SIGNATURE: |  | DATE: |  |
|  | (Print patient name if minor) |  |  |

|  |  |
| --- | --- |
| SIGNATURE OF PARENT OR GUARDIAN: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| WITNESS: |  | DATE: |  |
|  | (Clinician Signature) |  |  |