AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name ____

Date of Birth __________________________________ Social Security Number ______________________

I give authorization and permission to **Oasis Counseling For Women & Children**

To: ☐ release to ☐ obtain from ☐ exchange with

Via: ☐ mail ☐ fax ☐ email ☐ verbal

Name ____ Title _________________________
Agency ____
Mailing Address____
City ____________________ State _______ Zip Code __________ Phone __________________

Information regarding my medical / psychological treatment, for the purpose of _______________________
Information to be released / obtained:

___ Intake and psychosocial history
___ Treatment summary including diagnosis
___ Discharge summary
___ Psychiatric consult & evaluation materials
___ Psychological testing & evaluation materials
___ Case summary
___ Other ____

Restrictions ____

It is understood that the duration of this consent will not be longer than would be necessary and reasonable to carry out the purpose for which it is given, and that I may revoke this consent in writing at any time. In the event that I revoke my consent, I understand that it shall not apply to any actions taken prior to the effective date of the revocation.

Date this release expires: ___________________________

I, the undersigned, acknowledge that I have read this authorization prior to its execution and fully understand the nature of the release.

____ Date ________________
Client or Parent/Guardian (please **print** and **sign**)

____ Date ________________
Witness (please **print** and **sign**)

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