REQUEST/AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name: _____
Client DOB: _____
Phone number: _____

I HEREBY AUTHORIZE: Caleb Dykes, ALC

To Release Information to: ☐ To receive information from: ☐

Name: _____
Relationship to Client: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: _____

The disclosure is at the request of the above-named client and for the purpose of:
☐ Continuity of Care ☐ Legal ☐ School ☐ Transfer of Care
☐ Other: _____
The type and amount of information to be used or disclosed:
☐ Entire Client Record ☐ Medication Records ☐ Emergency Contact ☐Treatment Plans ☐ Laboratory Results ☐ Financial ☐ Verbal Communication ☐ Psychiatric Evaluations ☐ Client Progress Notes ☐ Assessment Reports ☐ Diagnostic Testing Form(s):
_____

My legal representative or I hereby authorize the use or disclosure of information about the above-client and I understand that:
1. I may refuse to sign this authorization. I understand that my refusal to sign a release for my referral source will result in no communication between Caleb Dykes, ALC and the referral source.
2. I have the right to revoke this authorization orally or in writing. Any revocation will be effective only to the extent that action has not been taken in reliance on my prior authorization.
3. Unless revoked, this authorization will expire on _____.
(If left blank, this authorization will automatically expire upon termination of services).
4. By signing below, I recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure by the receipt of this disclosure.
5. Treatment will not be based on my signing this authorization.
6. I can receive a copy of this authorization upon request.

_____	_____
Print Client Name or His/Her Legal Representative	Representative Relationship to Client
_____	_____
Signature of Client Name or His/Her Legal Representative	Date Signed
_____	_____
Signature of Witness (Caleb Dykes, ALC)	Date Signed