Evolve
BEHAVIORAL SERVICES, LLC

AUTHORIZATION FOR USE/DISCLOSURE OF INFORMATION

Client name:	**Parent or Guardian:**	**Birth Date:**

TO:____ Release To:____

_____________________________________ ____

<u>Authorization for Use/Disclosure of Information</u>: I request and authorize the above-named doctor or health care provider to release the information specified below to the organization, agency or individual named on this request. I understand that the information to be released includes the following information:

Information Requested:	**Dates Covered:**
Copy of complete chart	Other:
Copy of assessment and treatment plans	Limited to treatment dates described below:
All treatment rendered in this office	

PURPOSE(S) OR NEED FOR WHICH INFORMATION IS TO BE USED:

Transfer of records	Consultation
Coordination of care	Other:
Change of provider	

AUTHORIZATION: I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire 365 days from the date of signature.

Patient name (print)	Signature of Person Authorized to sign for patient:	
Patient Signature	Date:	Relationship: