FOUNDRY
CLINICAL GROUP

AUTHORIZATION FOR RELEASE/EXCHANGE OF PROTECTED HEALTH INFORMATION (PHI)

Purpose: Continuation of care for _____
(*client name*)

Party to release/receive PHI:
Name(s): _____
Organization: _____
Phone/fax: _____
Address: _____
_____

If you wish to **RESTRICT** the exchange of information, please check which of the following you authorize to be released/exchanged:

❏ Aftercare Plan
❏ Diagnosis
❏ Treatment Plan
❏ Dates of Treatment
❏ Progress to Date
❏ Summary of Treatment
❏ Other:_____
_____
_____

This authorization will expire 90 days from termination of treatment, unless indicated otherwise as follows:_____

I understand that:

- This authorization is effective immediately and will expire on the date listed above.
- This authorization is voluntary.
- Treatment will not be affected if I do not sign this form. However, coordination of care may be adversely affected.
- This release/exchange of information is intended solely for the purpose of furthering treatment.
- I may revoke this authorization at any time by written notification. If I do revoke this authorization, it will not affect any actions taken before the revocation is received.
- Information disclosed as a result of this authorization may no longer be protected by federal privacy laws and may be disclosed by the company or individual receiving the information.
- A photocopy of this authorization shall be considered as effective and valid as the original.
- I have a right to receive a copy of this document.

I hereby authorize clinicians at Foundry Clinical Group, including, but not limited to, Aaron Alan, MFT, CSAT, Jenner Bishop, MFT, CSAT, Thuy Buy, LCSW, CSAT, Christopher Donaghue, PhD, LCSW, Nicole Ashton, MFT, CSAT, Brooke Alderman, MA, Justin Natoli, MA, and Rory Reid, PhD, LCSW, to disclose/exchange Protected Health Information (PHI). Applicable rules of confidentiality will be observed regarding any information, written or verbal, that is released/received under this agreement.

I have read, understand and agree to this Authorization.

Signature:_____ Date:_____

Printed Name: _____