Authorization for Release/Exchange of Protected Health Information (PHI)

Purpose: Coordination/continuity of care for _____
(Client Name)

Party to Receive/Release PHI:

_____
(Name) (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	❏ Dates of Treatment	❏ Other:_____
❏ Diagnosis	❏ Progress to Date	_____
❏ Treatment Plan	❏ Summary of Treatment	_____

I hereby authorize staff clinicians at Foundry Clinical Group, including (but not limited to) Jenner Bishop MFT, Aaron Alan MFT and Sharon Lee MFT to release/exchange my Protected Health Information both within Foundry Clinical Group and to the specific party designated above.

Applicable rules of confidentiality will be observed regarding information that is received under this agreement. *Your records will be released with careful clinical consideration.*

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.
- This exchange and/or receipt 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.

_____ _____
Signature Date

_____
Printed Name