Cedar Creek Associates

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Authorization for Release of Information

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

☐ I authorize _____ to

Release information to:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # (include area code)

_____
Fax # (include area code)

☐ I authorize _____ to

Release information to:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip Code

_____
Phone # (include area code)

_____
Fax # (include area code)

PURPOSE OF THIS REQUEST: (circle one) ☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Other

TYPES OF RECORDS AUTHORIZED: ☐ Psychiatric/Psychological Evaluations and/or Treatment
☐ Drug/Alcohol Evaluation and/or Treatment

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

☐ Assessments ☐ Progress Notes ☐ Test Results: _____ ☐ Diagnostic Impression
☐ Discharge Summary ☐ Treatment Plans ☐ Treatment Summary
☐ Other: (please describe)_____

Periodic Use/Disclosure: I Authorize the periodic use or disclosure of the information described above to the person/provider/organization/program(s) identified as often as necessary to fulfill the purpose identified in this document. My authorization will expire:

☐ One year from this date ☐ Other _____

Signature of Client: _____ Date: _____