Release of Information

> This form must be filled out if billing, appointments, or care are to be discussed with anyone other than the client or their legal guardian.

Please select one to begin.

Prescribing or Mental Health Provider

I hereby authorize Alliance Mental Health to use or disclose the specific information described below, only for the purposes and parties also described below.

For the purposes of coordination of care the below identified provider will be automatically notified of the following:

- Notification that you are a client of Alliance Mental Health.
- Notification when you are no longer a client of Alliance Mental Health

Information that may be exchanged with the below provider as needed for coordination of care includes:

- Dates of service
- Diagnosis and corresponding recommendations or limitations
- Information concerning your treatment plan and sessions

Information to be exchanged with:

Name and Organization (if applicable)

Phone

Email

Street Address

I understand that:

- This authorization will remain in effect for one year or until revoked.
- I may revoke this authorization in writing by contacting Alliance Mental Health.
- I may inspect or copy the protected health information to be used or disclosed.
- This authorization gives Alliance Mental Health the right to discuss my medical information with one or more people listed above.
- I may ask Alliance Mental Health not to use or share certain health information for treatment, payment or operations and that Alliance Mental Health is not required to agree to that request if it would affect my care.

Client Name

Client Date of Birth

Client Signature (Guardian if Client is a minor)

Date of Signature

Name of Guardian (if applicable)