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.

Other (family, friend, social worker etc)

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

Description of the specific information to be released, exchanged, or discussed:

- [ ] Scheduling
  Scheduling or cancelling sessions
- [ ] Diagnosis
  Diagnosis and corresponding recommendations or limitations
- [ ] Care Plan
  Information concerning sessions and therapeutic plan
- [ ] Billing
  Balances and statements which do include session dates
- [ ] Other
  Please Specify in Additional Notes Below

Additional Notes:

Please specify any detail about what you want shared or what you prefer not to share.

Information to be exchanged with:

Name and Organization (if applicable)

Relationship to Client

Phone

Email

Street Address

Information used or disclosed pursuant to the authorization with anyone not subject to the rules of HIPAA may be subject to re-disclosure by the recipient and no longer be protected by HIPAA.

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)