Authorization to Release or Exchange Confidential Information

I, [Name of Client] ______________________________________(“Client”) hereby authorize the Sigil Social Foundation (“Provider”) to release or exchange confidential information obtained during the course of my treatment to [name or function of the person(s) or entities to whom information is to be released or exchanged]_______________________________(“Recipient”).

This Authorization permits the release of the following information:

☐History	☐ Court/Agency Documents	☐ Family Eval
☐ Discharge Summary	☐ Mental Status	☐ Treatment Plan(s)
☐ Psychiatric Evaluation	☐ Progress Notes	☐ Diagnoses
☐ Psychological Tests	☐ Consultation Reports	☐ Attendance Record
☐ Chemical Recovery History	☐ Educational Records	☐ Medical Records
☐ Crisis Intervention Reports	☐ Psychosocial Reports	☐ Lab Results
☐ Dates of Hospitalization	☐ Verbal Discussion of Progress of Therapy/Collaboration	
☐ Any and All Information Necessary		☐ Other (specify below)

____

I authorize the release of the information described above for the following purpose(s):
____
____

I understand that I have a right to receive a copy of this Authorization, and that any modification or revocation of this Authorization must be in writing. I certify that this form has been fully explained to me and that I understand its contents.

The Authorization shall remain valid until: ______________________________
(“Expiration Date”)

By:

____
Signature of (Client or Client’s Representative)

____
Date of Authorization

____
Signature of Witness (Therapist)

____
Date Witnessed