**RELEASE AND EXCHANGE OF INFORMATION AUTHORIZATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (client/guardian name) consent to the release of information by

\_\_\_\_\_written, \_\_\_\_\_faxed, \_\_\_\_\_electronic, or \_\_\_\_\_verbal communication (check all that apply),

**Between**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (name of provider)

North Shore Psychotherapy Associates

5555 N. Port Washington Road, Suite 300

Glendale, WI 53217

Telephone: 414-962-6764 Fax: 414-962-6765

**And**

|  |  |
| --- | --- |
| **Name:** | |
| **Address:** | |
| **Phone:** | **Fax:** |
| (Name of Agency/Provider) | |

I hereby authorize and request you to release the complete history, records and other relevant information in your possession, concerning treatment and/or evaluation, except that raw test data may only be released to someone who is trained to interpret that data regarding the individual named below. This information is to be used for purposes of coordination of care. This release is intended for the following:

\_\_\_\_\_ all dates of service

\_\_\_\_\_ treatment dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that I may revoke this authorization at any time, except to the extent that the action has already been taken in reliance upon this authorization. If not previously revoked, this authorization will terminate on the following date, event or condition: If no date, event or condition is specified, this authorization will expire one year from the date of signing or when the court actions have terminated, whichever is later. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

**Client/Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **State:** \_\_\_\_\_\_\_\_\_\_ **Zip Code:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Client/Patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Parent/Guardian Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_