

Authorization for Release of Information

Name: _____ Date of Birth: _____
Address: _____ City, State, Zip: _____
Phone Number: _____ E-mail: _____

I authorize *Dr. Heloisa Portela* to release and/or exchange information with:

_____ (Name of Person and/or Agency)

_____ (Complete Address)
_____ (Phone Number)

This information exchange will include:

- | | | |
|--|---|--|
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Diagnostic Impression | <input type="checkbox"/> Treatment Summary |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Treatment Plans | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Psychiatric Records | <input type="checkbox"/> Educational Records | <input type="checkbox"/> Psychological Testing |
| <input type="checkbox"/> Medical Records | <input type="checkbox"/> Therapy Notes | <input type="checkbox"/> Laboratory Test results |
| <input type="checkbox"/> All the Above | <input type="checkbox"/> Other: (specify) _____ | |

Purpose of this request:

- Coordination of Treatment Insurance Coverage Personal Other

One time use/Disclosure: I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified.

My authorization will expire:

- When the requested information has been sent/received.
 90 days from this date. Other: _____

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

My authorization will expire:

- When I am no longer receiving services from Dr. Heloisa Portela.
 One year from this date. Other: _____

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a written request to Dr. Heloisa Portela, except to the extent that action has already been taken in accordance to my prior authorization.
- If the person or facility receiving the information is not a health care or medical/insurance provider covered by privacy regulations, the information stated above could be re-disclosed.
- The information exchange may be communicated by written, oral or electronic means.
- Release of HIV-related information requires additional information.
- If the medical record information is not sent to another care provider, these may be a change of the requested records.

Signature of Client or Representative: _____ Date: _____

Relationship to client:

- Self Parent Legal Guardian Other: _____