SENIOR CONNECTIONS
Every Person Deserves Understanding

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AUTHORIZATION TO RELEASE RECORDS OR INFORMATION

Client Name: _____ Date of Birth: _____

Treatment Dates: _____ Clinician: _____

Purpose of Disclosure or Release:

_____

- ☐ Discharge Summary
- ☐ Psychological Test Results
- ☐ Estimate Length of Treatment
- ☐ Summary of Treatment & Progress
- ☐ Psychosocial Assessment
- ☐ Diagnostic Interview
- ☐ Therapist's Notes
- ☐ Other (specify) _____
- ☐ All of the above

I understand that my records are confidential and cannot be disclosed without my written authorization, except as otherwise provided for by law. I also understand that records pertaining to the diagnosis and/or treatment of HIV/Aids, psychiatric illnesses, psychological disorders and alcoholic or chemical abuse and dependence will be released per my specific consent to release as indicated by this document. A facsimile or photocopy of this authorization may be accepted.

This authorization may be revoked at any time.

RELEASE

I, _____, hereby authorize _____

_____ of Senior Connections, to release information (as checked or specified above) to:

_____

_____

OBTAIN

I, _____, hereby authorize _____

_____ to release information (as checked or specified above) to Senior Connections.

_____ _____

Patient/Legal Guardian *Witness*

_____ _____

Date *Date*