**Authorization to Release Confidential Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize Canopy Counseling Unlimited to release,

 Your name/client/parent/guardian

request, and exchange \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Name of client*

information and records obtained in the course of my diagnosis and treatment for the following purposes:

 Increase understanding of my previous history, diagnosis, and treatment

 Coordinate care on an ongoing basis with other providers who are also treating me

 Discuss my care with friends or family who may be important sources of support

Information can be released to, requested from, or exchanged with the following individual or

organization:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*The person or organization we can talk to- Name of individual/organization Address Phone number / fax*

I authorize

 An exchange of information between Canopy Counseling Unlimited and the individual or organization listed above.

 A release of information from Canopy Counseling Unlimited to the individual or organization listed above.

 A release of information to Canopy Counseling Unlimited from the individual or organization listed above.

This release shall be limited to the following information (**circle all that apply**):

 Attendance in therapy

 Diagnosis

 Summary of psychosocial and psychiatric history and treatments

 Medical information, including the results of medical tests and medication

 Results of psychological tests

 Behavioral reports and observations

 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that that this release is valid for a period of 120 days. I further understand that I may revoke this authorization at any time in writing. In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Client name Signature of client, parent, or legal guardian Date*