TRINITY
CHAPLAINCY & COUNSELING
Relieving suffering, Revealing God

Release of Information

Provider name: _____

Address: _____

Phone: _____ Email: _____

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Client name: _____

Date of Birth: _____ Phone: _____

Address: _____

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I, _____, authorize _____ to release information to _____ and that they may share information between both parties.

I, _____, authorize the release of (select all that apply)

_____ Treatment progress notes _____ Diagnostic information _____ Treatment plan

_____ Attendance verification _____ Testing/evaluations _____ Other (describe below)

_____

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This authorization expires one year from the date signed or until _____

I may revoke this release by submitting a written notice to my provider.

My treatment, payment, and eligibility for services are not conditioned on signing this release.

I have the right to receive a copy of this release. Information disclosed may be subject to HIPPA.

Client/Patient _____ Date: _____

Provider: _____ Date: _____

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