AUTHORIZATION TO RELEASE OR OBTAIN CONFIDENTIAL INFORMATION

Please complete this form if you are using in-network insurance, EAP and/or would like us to collaborate with your other providers.

I, _____ (full name), DOB _____/_____/_____,
authorize Grief Recovery Center to:

☐ **Release To:** ☐ **Obtain From:**

_____
Name

_____
Address

(_____) - _____ (_____) - _____
Phone Fax

For the purpose of:

☐ Insurance/EAP ☐ Legal ☐ Continuity of Care ☐ Transfer of Care ☐ Personal Use

I agree to release the following information:

☐ **ALL RECORDS** ☐ Diagnosis ☐ Treatment Plan ☐ Session dates/times ONLY

☐ Progress notes ☐ Progress to date ☐ Symptoms ☐ Prognosis

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that it any event this consent shall expire 90 days after the date the client discharges, unless another date is specified.

Specification of the date, event or condition upon which this consent expires: _____

I understand that the health information disclosed pursuant to this authorization may be subject to re-disclosure by Recipient and that Federal Privacy Rule may no longer protect such information although the re-disclosure of such information may be protected by applicable law.

_____
Printed Name of Client

_____
Client's Signature and Date

_____
Printed Name of Legal Guardian (if client is under age 18)

_____
Legal Guardian's Signature (if client is under age 18) and Date