FAMILY FOCUS & ASSOCIATES

Authorization for Release of Information

PATIENT

Last Name _____ First Name _____

Address _____

City _____ State _____ ZIP _____

Phone ( ) — Birthdate / /

REASON

- [x] Communication about treatment between healthcare providers
- [ ] At request of patient or patient's representative
- [ ] Records copied, sent to requestors and billed to patient

DATES

- [x] Beginning of treatment through continuity of care
- [ ] Dates of / / through / /

RECORDS

- [ ] Complete records **excluding** psychotherapy notes
- [x] Complete records **including** psychotherapy notes
- [ ] Other: _____
- [ ] Information to be excluded: _____

Release of Information

I hereby authorize my clinician(s) at Family Focus & Associates to verbally release the information identified in this authorization to:

_____

_____

_____

Release of Records

I hereby authorize my clinician(s) at Family Focus & Associates to release the medical records identified in this authorization to:

_____

_____

_____

I understand that I am not required to sign this authorization and treatment will not be denied if I do not. I understand that the records I authorize for release may contain private information about me or my significant others, including any history of substance abuse, genetic conditions or psychiatric issues. I understand that once information has been released, it could be redisclosed. I hereby release, discharge and hold harmless Family Focus LLC and its independent contractors from any liability for complying with this authorization.

_____ _____ / /

SIGNATURE OF PATIENT
(or parent/guardian if a minor)

PRINTED NAME

DATE