FLOURISH
counseling
milwaukee

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Information	Name _____ Date of Birth _____ Address _____ City _____ State _____ Zip Code _____ Phone Number_____
Clinic/Health Care Provider *Who has the information to be released?*	Name _____ Address _____ City _____ State _____ Zip Code _____ Phone Number_____
Receiving Party *Who will the information be released to?*	Name _____ Relationship to Client_____ Address _____ City _____ State _____ Zip Code _____ Phone Number_____
Information to Be Released *What will be released?*	□ Whether the client is in treatment or not □ Prognosis (diagnosis, opinion of how treatment will benefit client, general peculiarities of case) □ Nature of the project (services offered, purpose and philosophy of program) □ Brief statement regarding progress (client's denial, client's understanding of their condition and the disease concept, progress or lack of progress on goals, cooperation with treatment plan and rules) □ Any information needed for continuity of care
Purpose of Release *Why is information*	□ Referral to other services □ Coordination of care

being released?	□ Consultation with Doctor □ Consultation with other mental health provider □ Transfer of care □ Other _____

Signature of Client_____ Date_____

Signature of Guardian (if applicable)_____ Date_____

Signature of Provider _____Date_____

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____. This authorization may be canceled in writing at any time. A photocopy/fax of this authorization will be treated in the same way as an original. Your signature indicates that you have read and understand this form, and authorize release of your information as described above. I understand that I may refuse to sign this authorization and that refusal to sign will not affect treatment.

Our Contact Information:
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Instructions: Both your clinician and the outside party you are requesting contact for must have a physical copy of this authorization form before any communication may be made. Please return the original to your counselor at Flourish, and provide a copy to the other party. You may want to keep a copy for your own records.