ClearPath Psychiatry & Counseling

Release of Information Authorization

Patient Name: _____ DOB: _____

I authorize ClearPath Psychiatry & Counseling to ☐ RELEASE TO and/or ☐ OBTAIN FROM:

Name of Person/Organization:

_____

Address:

_____

___

Phone: _____ Fax:

_____

Information to be released/obtained:

☐ Intake Evaluation ☐ Treatment Plan ☐ Medication Records

☐ Progress Notes ☐ Discharge Summary ☐ Other: _____

This authorization is valid for one year from the date signed unless revoked in writing earlier.

Patient/Guardian Signature: _____ Date:

_____