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Authorization for release of information

Patient: _____ DOB: _____

- □ I authorize the release of information ***to*** Edelweiss Behavioral Health and the person or organization listed below
- □ I authorize the release of information ***from*** Edelweiss Behavioral Health and the person or organization listed below
- □ Please release my medical records to the agency/person listed below Please specify: _____

Agency/Person: _____

_____

_____

_____

My signature below acknowledges my understanding of the following:

- I am allowing an exchange of the following information via written or verbal communication:
  - Medical Information
  - Mental Health/psychiatric information
  - Substance use information

I have a right to a copy of this authorization.

This release is valid from the date of signing until six months after the termination of treatment.

I realize that I have the right to revoke this authorization at any time.

I may place restrictions on the type of information and the means of communication as described here.

___ No restrictions ___ Restrictions (describe): _____

_____

Patient signature: _____ Date: _____

Legal guardian: _____ Date: _____

Notice of revocation-this revocation cancels any authorization given above: _____

Manner in which revocation request was received: _____

Date revocation was received: _____