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**Release of Private Health Information**

<b>Client name:</b>	<b>DOB:</b>
<b>Address:</b>	<b>Phone number:</b>

**I give permission for Eastside Mental Wellness to release/receive information from:**

<p><b>Person or Agency:</b></p> <p><b>Address:</b></p> <p><b>Phone number:</b></p> <p><b>Fax/Email:</b></p>
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**The following information regarding the client/family: (check box)**

<input type="checkbox"/>	Initial Assessment
<input type="checkbox"/>	Information on Progress in Therapy
<input type="checkbox"/>	Treatment Plan
<input type="checkbox"/>	Medical Information
<input type="checkbox"/>	Termination Summary
<input type="checkbox"/>	Other:

**For the purpose of:**

<input type="checkbox"/>	Coordination of Services
<input type="checkbox"/>	To Assist in Evaluation
<input type="checkbox"/>	To Provide Continuity of Treatment
<input type="checkbox"/>	Other:

I understand that I can revoke this authorization at any time, except to the extent that action has already taken place. If not revoked at an earlier date, this authorization will expire one year from the date signed.

I understand that the specific type of information to be disclosed may include a history of DRUG or ALCOHOL, ABUSE, or MENTAL HEALTH TREATMENT.

\_\_\_\_\_  
Client name Date

\_\_\_\_\_  
Witness Date