**Release of Information Form**

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I request Rebecca Barrett, MSW, LSWAIC to disclose my private health information as specified below.

The nature of the information to be disclosed is (check one):

- □ my entire treatment record
- □ presence & participation in treatment
- □ diagnosis
- □ assessment
- □ scheduling information
- □ financial & billing information
- □ information relevant for coordination of care
- □ treatment summary
- □ other _____

The information to be disclosed specifically **does** include (check all that apply):

- □ psychotherapy notes
- □ information related to substance abuse assessment and treatment

The information specified above will be disclosed to:

Name _____ Institutional/Agency Affiliation_____
Contact info: _____

This authorization of disclosure of my health information will expire on _____
(date or event)

I understand that my protected health information disclosed pursuant to this agreement may be subject to redisclosure by the recipient and in such cases may no longer be protected by state or federal rules of confidentiality.

I understand that I have the right to refuse to sign this form for authorization to disclose or release my protected health information and that my refusal to sign this authorization will not adversely affect my ability to receive health care services.

I understand that I may revoke this authorization in writing at any time. If I revoke this authorization, the information described may no longer be used or disclosed as described in this authorization unless action has already been taken in reliance on this authorization.

_____ _____
Client Date

_____ Print Client Name