



## Authorization for the Release or Exchange of Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Authorization to:

Release       Exchange

Information to be released or exchanged with:

\_\_\_\_\_  
(Name of Person or Organization)

Information to be released or exchanged:

<input type="checkbox"/> Social History/Clinical Interview	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Psychological Testing	<input type="checkbox"/> Chemical Dependency History
<input type="checkbox"/> Dates of Treatment	<input type="checkbox"/> Mental Status
<input type="checkbox"/> Treatment Plans	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Diagnoses	<input type="checkbox"/> Crisis Intervention Reports
<input type="checkbox"/> Educational Records	<input type="checkbox"/> Educational Tests/Reports
<input type="checkbox"/> Attendance Record	<input type="checkbox"/> Comprehensive Treatment Summary
<input type="checkbox"/> Medical Records	<input type="checkbox"/> Other (Specify): _____

\_\_\_\_\_  
Patient/Guardian Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
PMCC Staff Signature

\_\_\_\_\_  
Date Signed

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