

NARANJO THERAPY

RELEASE OF INFORMATION FORM

Client Information	Name _____ Date of Birth _____ Address _____ City _____ State _____ Zip Code _____ Phone Number _____
Clinic/Health Care Provider Who will release the information?	Name _____ Address _____ City _____ State _____ Zip Code _____ Phone Number _____
Receiving Party Who will the information be released to?	Name _____ Relationship to Client _____ Address _____ City _____ State _____ Zip Code _____ Phone Number _____ Fax Number _____
Information to Be Released What will be released?	<input type="checkbox"/> Whether the client is in treatment or not <input type="checkbox"/> Prognosis (diagnosis, opinion of how treatment will benefit client, general peculiarities of case) <input type="checkbox"/> Brief statement regarding progress (client's denial, client's understanding of their condition and the disease concept, progress or lack of progress on goals, cooperation with treatment plan and rules) <input type="checkbox"/> Treatment history
Purpose of Release Why is information being released?	<input type="checkbox"/> Referral to other services <input type="checkbox"/> Coordination of care <input type="checkbox"/> Consultation with Doctor <input type="checkbox"/> Consultation with other mental health provider <input type="checkbox"/> Transfer of care <input type="checkbox"/> Other _____

Signature of Client _____ Date _____

Signature of Provider _____ Date _____

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____.
 This authorization may be canceled in writing at any time. A photocopy/fax of this authorization will be treated in the same way as an original. Your signature indicates that you have read and understand this form, and authorize release of your information as described above. You may refuse to sign this authorization and that refusal to sign will not affect treatment.