INNOVATION
Behavioral Health Solutions, LLC
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RELEASE OF INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

1. I, _____, hereby voluntarily authorize the disclosure of information from my record.
   (client name)

2.

The information is to be disclosed by:	The information is to be provided to:
NAME OF PERSON/FACILITY	**NAME OF PERSON/FACILITY**
ADDRESS	**ADDRESS**
CITY/STATE/ZIP	**CITY/STATE/ZIP**

3. The purpose or need of this disclosure is: _____

_____

4. The information to be disclosed from my record: (check appropriate box(es))

   ☐ Only information related to (specify) _____

   _____

   ☐ Only the period of events from: _____

   ☐ Psychotherapy Treatment Summary

   ☐ Psychological Testing Report

5. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization. This consent shall become null and void six months after the last date of service. Unless revoked, this authorization will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event. EXPIRATION DATE OF AUTHORIZATION _____

_____ _____
SIGNATURE OF PATIENT or AUTHORIZED REPRESENTATIVE DATE

_____ _____
WITNESS DATE