Mandy Jordan, PhD
Trauma Specialist

Client Information:

Name_____

Date of Birth_____

Address_____

City_____State_____Zip Code_____

Phone Number_____

Clinic/Health Care Provider:

Who has the information to be released?

Name_____

Address_____

City_____State_____Zip Code_____

Phone Number_____Fax Number_____

Receiving Party:

Who will the information be released to?

Name_____

Address_____

City_____State_____Zip Code_____

Phone Number_____Fax Number_____

- ☐ I provide my consent to have both parties discuss my treatment with one another

Information to be Released:

What will be released?

- ☐ Whether the client is in treatment or not
- ☐ Prognosis (diagnosis, opinion of how treatment will benefit client, general peculiarities of case)
- ☐ Nature of the treatment (Services offered, purpose and philosophy of treatment)

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- ☐ 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)
- ☐ Whatever is needed for continuity of treatment
- ☐ Other:_____

Purpose of Release:

Why is information being released?

- ☐ Referral to other services
- ☐ Coordination of care
- ☐ Consultation with Doctor
- ☐ Consultation with other mental health provider
- ☐ Transfer of care
- ☐ Other:_____

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 understand that you may refuse to sign this authorization and that refusal to sign will not affect treatment.

Signature of Client:_____

Date:_____

Signature of Provider:_____

Date:_____