McGuire
Therapeutic Services

*"Encouraging Personal, Relationship, and Spiritual Growth"*

# AUTHORIZATION FOR THE RELEASE OF INFORMATION

I, _____ fully authorize McGuire Therapeutic Services to release/receive information regarding my Healthcare to:

Name/Agency: _____ Relationship to Client: _____

Address: _____

City, State, Zip: _____Phone# _____ Fax # _____

For the following purposes:

□ Copies of Records □ Discharge Summaries □ Consultation □ Treatment Planning

□ Medication Information □ Diagnostic Information □ Financial/Benefits Information

□ Discharge/Follow-up Care □ Necessary Rehabilitation Information □ Other/Relevant Information _____

The information will be communicated via_____ Telephone_____ Correspondence and is authorized to be

Communicated both ways_____ Yes_____ No.

The requested information will be used to help _____formulate psychiatric rehabilitation goals and _____

Coordinate treatment across my healthcare team.

I know that this authorization is voluntary, and will not affect my healthcare and payment if I refuse to sign it.

I understand that I may review the requested information, request and keep upon receipt, a copy of this authorization after I sign it.

I understand that the information provided by this request will be held in the strictest of confidence and is to be used only by the professionals on my healthcare team.

This authorization can be cancelled by me at any time, unless a process has already started and its completion depends of this authorization.

Signature: _____ Date:_____

Expires on: _____ (One year from today)

Witness: _____ Date: _____