DART Center, LLC

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Authorization to Release Information

Client Name_______ SSN (Last 4 digits)_____DOB: _____

I hereby authorize DART Center to release my information to:

Name of Person or Organization: _____ Phone: _____

Address:_____

The purpose for the release: Continuity of care: ___X__Other: _____

I authorize the following (checked) information to be released from my mental/behavioral health records:

☐ History	☐ Psychosocial Assessment	☐ Medications
☐ Psychiatric Eval/Tests	☐ Psychosocial Eval/Tests	☐ Psychological Testing Results
☐ Progress Notes	☐ Physician Orders	☐ Alcohol/Drug Assessments
☐ Discharge Summary	☐ Treatment Plan	☐ Alcohol/Drug Treatment Records
☐ Group Therapy Notes	☐ Psychotherapy Notes	☐ Other (Please Specify):

_____

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon this authorization. If not previously revoked, this authorization will terminate on the following date, event or condition:_____. If no date, event or condition specified, this authorization will expire after two years from the date of my signature.

I understand that no treatment, payment, enrollment or eligibility for benefits may be conditioned on whether I sign this authorization.

The information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by federal law(45 CFR Part 164).

I understand that I am entitled to a copy of this authorization.

Signature of Client or Legal Representative: _____Date:_____

Print Name of Legal Representative: _____ Relationship to Patient_____