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# Authorization Form for Release of Clinical Record

*This form when completed and signed by you, authorizes us to release protected information from your clinical record to the person you designate.*

Client's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

I, \_\_\_\_\_, and I, \_\_\_\_\_  
Client (if 18 or older) or parent/guardian 1 of minor parent/guardian 2 of minor

authorize Alvord, Baker & Associates, LLC to release/receive and exchange information from the client record.

I/we are requesting that Alvord, Baker & Associates, LLC release this information for the following reasons:  
(*"at the request of the individual"* is all that is required if you are the client or parent/guardian of the client, and you do not desire to state a specific purpose.)

Provide description of the information that you want disclosed. Your description should be as specific and detailed as possible.

I understand that my therapist cannot re-disclose information he/she received from another health care provider if that health care provider requested that the information not be redisclosed.

This authorization shall remain in effect for a period of one year from the date below or until \_\_\_\_\_.

The information is to be released to/from:

Name: \_\_\_\_\_ Position: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

I/we understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Alvord, Baker & Associates, LLC. However, the revocation will not be effective to the extent that action taken in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I/we understand that my therapist(s) generally may not condition psychological services upon the signing of an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party. I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.

\_\_\_\_\_  
Client (if 18 or older) or parent 1 /guardian 1 signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name

\_\_\_\_\_  
Client (if 18 or older) or parent 2 / guardian 2 signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name