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Authorization for Release of Information

Full Name: _____

Date of Birth (DOB): _____ /_____ /_____ Social Security #: _____

I hereby authorize the release of the following specific information:

- ☐ Medical History
- ☐ Psychological Examination & Tests
- ☐ Discharge Summary
- ☐ Letter indicating diagnosis and access to mental health benefits
- ☐ Other: _____
- ☐ Psychiatric Evaluation
- ☐ Summary of Mental Health Treatment
- ☐ Treatment Updates

☐ **from Jennifer VanOrman, LMFT, to** _____

☐ **to Jennifer VanOrman, LMFT, from** _____

I hereby authorize the release of the following specific information:

- ☐ To improve assessment and treatment planning
- ☐ To coordinate the medical, psychological, and social rehabilitative process
- ☐ To provide mental health and treatment plan information to my managed care company
- ☐ Other. Please specify: _____

This authorization form is valid for one year unless I notify Jennifer VanOrman, LMFT, in writing to revoke this permission. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. I understand that once information has been released to outside parties, Jennifer VanOrman, LMFT, no longer has control over it. Furthermore, I understand that privacy laws may no longer protect my private health information and that it may be disclosed by the receiving party without my knowledge. I understand that a copy may serve the same purposes as the original. I give permission to Jennifer VanOrman, LMFT, to disclose information as permitted by this authorization in any manner that she deems to be appropriate and consistent with applied law, including, but not limited to, verbally, electronically transmitted or by paper format.

_____ _____
Signature Date of Request

_____ _____
Witness Relationship to Client