www.foundationtherapies.com
651-472-6535

Authorization to Release Confidential Information

I authorize Foundation Therapies, Inc. and ______________________________________
(treating therapist name)

to release the following information obtained during the course of treatment for:
____ to:
(Client Name)

Person/Agency: ____

Address: ____

Phone: ________________________________ Fax: ____________________________

This authorization permits the release of the following information (check all that apply):

- ☐ Any and All information Necessary
- ☐ Verbal Exchange
- ☐ Summary of Care
- ☐ Diagnostic Assessment
- ☐ Treatment Plan
- ☐ Medication Information (current)
- ☐ Psychological Testing Results
- ☐ Appointment Information
- ☐ Other: ___________________

_______ I agree HIV status and/or drug/alcohol usage may be disclosed.
(initials)

This information will be used for the following purpose (check all that apply):

- ☐ Treatment
- ☐ Care Coordination
- ☐ Litigation
- ☐ Other: ____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be made in writing. This authorization shall remain valid for one year from date signed or until discontinuation of services.

______________________	______________________	______________
Print Name	Client - Signature	Date