A.B.L.E.

**2100 E. Broadway, Suite 200A**
**Columbia, MO 65201-6082**
**Phone 573.214.2253 Fax 573.474.5683**
**www.ABLEWellnessCenter.com**

# AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION
**(Optional)**

***This form, when completed and signed by you, authorizes ABLE to release protected information from your clinical record to the person you designate***
***AND/OR***
***This form, when completed and signed by you, authorizes ABLE to obtain protected information from your clinical record from the person you designate.***

**RE: _____ (Client) DOB: _____**

I, _____, authorize _____(Provider Name).
*(Client or Parent/Guardian)*
2100 E. Broadway, Suite 200A
Columbia, Missouri, 65201-6082
Telephone: 573-214-2253
Fax: 573-474-5683

_____to release information to;_____ to obtain information from;_____ to exchange information with;
*(initial to indicate selection)* *(initial to indicate selection)* *(initial to indicate selection)*

Name: _____ Agency: _____

Address: _____

Phone: (_____)_____ FAX: (_____)_____

The following information may be released/obtained/exchanged, as indicated above, in the form of written records and/or verbal communication regarding the above-stated client.

| | | |
|---|---|---|
| ❑ All Records | ❑ Treatment Summary | ❑ Diagnostic Summary |
| ❑ Test Results | ❑ Progress Notes | ❑ Other: _____ |
| ❑ Treatment Plan | ❑ Evaluation Summary | _____ |

This confidential information may be released only for the following purpose(s):

_____

_____

_____

I understand that the individual from whom I am receiving services, generally, may not make the signing of an authorization a requirement of receiving psychological services *unless* the psychological services are provided to me for the purpose of creating health information for a third party (i.e., court-ordered psychological testing).

I understand that the information to be disclosed is protected by law, and that the same information may be subject to disclosure by the recipient and may no longer be protected by the same law(s) that applied in the first instance.

Client signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____

Witness signature: _____ Date: _____

*If the client is under the age of consent (12 years of age) or has a court-appointed guardian, this release must be signed by the client's parent or guardian in order to be valid.*

**Unless otherwise noted authorization shall expire one year from the date of this document.**

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**CANCELLATION/REVOCATION ONLY**

You have the right to revoke or cancel this authorization, in writing, at any time. To revoke or cancel this authorization, you may either sign below or send written notification of your intent to revoke or cancel to A.B.L.E.

However, your revocation or cancellation *will not* affect disclosures that already have been made by A.B.L.E:

- while the authorization was in effect
- if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Client signature: _____ Date: _____

Parent/Guardian signature: _____ Date: _____

Witness signature: _____ Date: _____