

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

Social Security Number: _____ Phone Number: _____

I authorize Terri Clinton Dichiser and Take Charge, Inc to release information to:

AND/OR

I authorize Terri Clinton Dichiser and Take Charge, Inc. to obtain information from:

Name of Provider or Facility

Name of Provider or Facility

Address

Address

City, State, Zip Code

City, State, Zip Code

Phone #/Fax # (Include area code)

Phone #/Fax # (Include area code)

Information or communication requested:

Purpose of release of information ("at the request of the individual" is sufficient):

I understand I have a right to copy and inspect the information being disclosed. I have the right to revoke this authorization in writing, at any time by sending such written notification to my provider's office. Written revocation is effective upon receipt. However, my revocation will not be effective to the extent my provider has taken action 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 understand my counselor may not condition counseling services upon my signing an authorization unless the counseling services are provided to me for the purpose of creating health information for a third party.

Authorization: I certify this request has been made freely, voluntarily and without coercion and the information given above is accurate and complete to the best of my knowledge. I understand I may have a copy of this form at any time I choose to request it. The authorization will automatically **expire in one year from the date of signature** or, if I prefer, on the date specified here: _____.

Full Printed Name of Patient

Signature

Date