HOPE FOR A BETTER TOMORROW

AUTHORIZATION TO REQUEST OR RELEASE INFORMATION

Client's Name: _____

Client's Address: _____

Date of Birth: (Month/Day/Year): _____

I ,_____, authorize:

Hope for a Better Tomorrow
2607 N. Grandview Blvd, #110
Waukesha, WI 53188
Phone: 262-313-8339 Fax: 262-910-1653

Therapist Name:_____

To Disclose to **and** obtain information from:

Name:_____
(agency, organization, school, hospital, professional, etc.)

Address: _____

Phone: _____ Fax: _____

The following information:

___ Initial Evaluation/Assessment
___ Medication Records
___ Family Correspondence: Making/Checking appointments
___ Family Correspondence: Progress update of client
___ Billing and Payments
___ Other:_____
___ Progress Notes
___ Psychological Testing Report
___ Treatment Plan
___ Discharge Summary

For the purpose of (specify):

___ Diagnosis and Treatment ___ Effective Treatment Planning ___ Coordination of Care
___ Other:_____

This authorization can be terminated at any time in writing.
This authorization is valid for the duration of involvement, up to one year

Signed:_____ (Client 12 years of age and older)	_____ Date	_____ Witness
Signed:_____ (Parent or legal guardian)	_____ Date	_____ Witness