HOPE FOR A BETTER TOMORROW

AUTHORIZATION TO REQUEST OR RELEASE INFORMATION

Client's Name: ____

Client's Address: ____

Date of Birth: (Month/Day/Year): ____________________ Phone #:____________________

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
___ Progress Notes
___ Psychological Testing Report
___ Treatment Plan
___ Discharge Summary
___ Other:____

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