AUTHORIZATION TO RELEASE INFORMATION

I voluntarily authorize, **The ITM Group.**, to:

Obtain from_____ Release to____ Exchange with____ (please initial an option)

_____NAME OF PERSON

_____NAME OF FACILITY

_____ADDRESS

_____CITY, STATE, ZIP

TELEPHONE#_____

Written and / or verbal information from the medical record / practitioner of:

Name of Patient _____Date of Birth_____

This information is to be used for the purpose of:
(Check those that apply)
- ☐ School placement
- ☐ Follow-up Care
- ☐ Outpatient treatment
- ☐ Insurance determinations
- ☐ Referral for services
- ☐ Other (Specify)_____

_____

Specific information to be released:
(Check those that apply)
- ☐ Psychiatric Discharge Summary
- ☐ Psychiatric Admission Summary
- ☐ Psychological Evaluation
- ☐ Master Treatment Plan
- ☐ History and Physical Examination
- ☐ Letter to Referral Source
- ☐ School Records / Information
- ☐ Outpatient Treatment Summary
- ☐ Other (Specify) _____

These records may include confidential psychiatric, psychological, drug, alcohol and / or medical information. Treatment is not conditional upon authorization to release information. To understand your privacy rights more fully please refer to our ***"Notice of Privacy Practices"***. This authorization expires ninety (90) days from the date of signature or from the date of termination of services, whichever is later, unless otherwise revoked by me in writing prior to that time. **The ITM Group,** is not to be held liable for any release of information made prior to receiving such notification.

_____ _____
Signature of patient Signature of parent / legal guardian

_____ _____
Witness Signature Witness Signature

_____ _____
Date Date