Link Therapy & Mediation
collaborate • connect • empower

AUTHORIZATION FOR EXCHANGE OF INFORMATION

I understand the information released may be subject to release by the person(s)/agency receiving it and no longer protected by the federal privacy regulations. I also understand that I may revoke this authorization by notifying Link Therapy and Mediation, in writing, of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by Link Therapy and Mediation in reliance on it before I revoked it. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment. A photocopy (or fax) of this authorization will be treated in the same manner as the original. I understand this release expires in one year unless otherwise noted below.

Client Name: _____ DOB:_____

Address: _____

I authorize Link Therapy and Mediation, LLC to receive information from and release information to:

Agency/Individual: _____

Address: _____

Phone: _____ Fax: _____

Information will be released ____ verbally and/or in ____writing (Check boxes that apply):

☐ All Records and Ongoing Communication OR

☐ Diagnostic Report	☐ Testing Results	☐ Psychological/ Psychiatric Evaluation	☐ Discharge Summary
☐ Treatment Plan	☐ Medical History		☐ Other: _____
☐ Progress Report	☐ Case Records	☐ Referral/ Consultation	
☐ School Records	☐ Family History		

This release is required for the purpose of (Check boxes that apply):

☐ Coordination of services	☐ Social service involvement	☐ Case review
☐ Planning appropriate treatment	☐ Continue/ follow-up care	☐ Other: _____

Client Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Therapist Signature: _____ Date: _____