#### AUTHORIZATION FOR RELEASE/REQUEST/EXCHANGE OF INFORMATION

I authorize the Robert D. Sutherland Center for the Evaluation and Treatment of Bipolar Disorder to [ ] release, [ ] request, or [ ]exchange information in either written or verbal form regarding

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s name Date of Birth

to/from/with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person/Organization

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Fax

I understand that the information to be released includes information regarding:

[X] Psychological or psychiatric conditions, if any;

[X] Alcohol and drug use, if any;

[X] Health related conditions (including HIV/AIDS), if any.

Information Requested/Released:

[ ] Written records

[ ] Verbal communication (e.g., telephone call)

[ ] Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dates covered:

[ ] All admissions/courses of treatment

[ ] From \_\_\_/\_\_\_/\_\_\_ until \_\_\_/\_\_\_/\_\_\_

Purpose or Use of Information to be Released:

[ ] Continuity/coordination of care [ ] Personal use [ ] Legal [ ] Occupational [ ] Other

I certify that this request has been made voluntarily. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken in reliance on this authorization. This authorization will automatically expire three months after I terminate services with the Sutherland Bipolar Center. Re-disclosure of my records by those receiving the authorized information is prohibited. I hereby release both of the above parties from any liability which may result from furnishing the information released, requested, or exchanged.

Signature of client/legal guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of client/legal guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_