



AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____ DOB : _____

Address: _____

Exchange of Information with (Name/Agency): _____

Address: _____ Phone : _____ Fax: _____

I, _____, freely give consent to **Vantage Point Behavioral Health** and the informant to exchange

Patient Name (self if over 16 in MD or legal guardian)

the *below* noted information for the purpose of payment, facilitating treatment, and continuity of care for me for my child.

- | | |
|--|--|
| <input type="checkbox"/> Notification of beginning and/or ending of treatment | <input type="checkbox"/> Intake assessment summary |
| <input type="checkbox"/> Periodic summary of treatment progress | <input type="checkbox"/> Past Treatment |
| <input type="checkbox"/> Psychological evaluation | <input type="checkbox"/> Financial Information |
| <input type="checkbox"/> Discharge summary | <input type="checkbox"/> Current psychiatric diagnosis |
| <input type="checkbox"/> List of current psychotropic medication and dosages | <input type="checkbox"/> Verbal exchange information |
| <input type="checkbox"/> Coordination of services agreement/treatment planning | <input type="checkbox"/> Other _____ |

If information is required for specific period of time, please specify from ___/___/___ to ___/___/___.

I understand that my provider may be supervised and that the supervisor will have access to confidential information. I agree that the provider's supervisor may substitute for the provider in exchange in information.

- Yes** **No, I do not wish for Vantage Point Behavioral Health to exchange information with anyone at this time.**

