Better Care Counseling
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Phone/Fax: 727-491-3999
https://bettercarecounseling.com

Authorization of Release of Information

1. Client's Name:_____ DOB:_____

2. Information to be released :
   - ☐ Summary of treatment to date
   - ☐ Report
   - ☐ Other: _____

3. Purpose of Disclosure
   - ☐ Coordination of Care
   - ☐ Other:_____

4. I authorize Better Care Counseling to send and receive the above information.

5. To / From:
   _____

6. Method of Disclosure
   - ☐ Written : _____
   - ☐ Verbal:_____
   - ☐ Electronic: _____

7. Today's date:_____Authorization to expire one year from signature date

I understand that my health information is protected by law. I authorize the release of my confidential health information as indicated above. I understand that my consent is voluntary and I can revoke this permission at any time, except to the extent that it has already been shared based on this authorization. Should I choose to revoke this authorization I will state this in writing.

Signature of Patient:_____Date:_____

Signature of Personal Representative: (If applicable) _____