Authorization for Release and / or Request of Information

Patient Full Name: _____

Date of Birth: ____ / ____ / ____ Social Security Number: ____ - ____ - ____

I HEREBY AUTHORIZE Earley Consultancy, LLC to:

[ ] **Release To** [ ] **Request From:** **[Check one or both]**

Name: _____

Organization: _____

Address: _____

City, State & Zip code: _____

Phone: _____ Fax: _____

Strike any items (1-17) that should NOT be included in this release.

1	Your Patient Demographic Information
2	History & Physical
3	Social History
4	Psychiatric Evaluation (data base)
5	Psychological Evaluation
6	Initial Clinical Assessment
7	Diagnoses
8	Compliance with Treatment
9	Laboratory Results (including urine drug screen results)
10	Written Correspondence

11	Diagnostic Test Reports (e.g. x-ray & scans)
12	Results of Consultation(s)
13	Telephone Reports & Verbal Communications
14	Care Plan
15	Discharge Recommendations
16	Discharge Summary
17	Financial Information
18	Other (specify):

I authorize Earley Consultancy, its employees and/or its HIPAA trusted parties to furnish information or receive information (as indicated from the list above) from or to the above listed organization or individuals. I understand this authorization is subject to revocation at any time except when action has been taken in reliance thereof. This authorization is valid for a period of two years from the date of my signature, unless I have specified another date or event listed below. Furthermore, I hereby release Earley Consultancy and its employees from any and all liabilities, responsibilities, damages and claims arising from the release of the authorized information. I understand the records released may contain sensitive materials including alcohol and/or drug information, information of a sexual nature and psychiatric information. Portions of the information disclosed may not pertain exclusively to my current diagnosis. I have been provided with the Privacy Policy of Earley Consultancy in compliance with federal regulations.

I opt for a release date other than 2 years from the date of my signature. The expiration date is: ____ / ____ / ____

_____ _____ / _____ / _____

Signature of Patient or Legal Guardian Date of Signature

_____ _____ / _____ / _____

Signature of Witness Date of Signature

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