Trust 2 Believe
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Authorization to Release Information

This authorization is separate from routine consent to treatment and is optional unless a specific lawful disclosure is needed. Complete all relevant fields before signing.

Client name and date of birth

Person / organization authorized to disclose information

Person / organization authorized to receive information

Address, phone or secure fax of recipient

Information to disclose (select all that apply)

- ☐ Dates of service
- ☐ Treatment summary
- ☐ Billing

Other specific records or information to disclose

Purpose of disclosure

Expiration date or specific expiration event

Authorization conditions

I understand I may revoke this authorization in writing, except where action has already been taken in reliance on it. Treatment, payment, enrollment, or eligibility generally will not be conditioned on signing except where law permits. Redisclosure may be possible depending on the recipient and applicable law.

Specially protected records, including psychotherapy notes and certain substance-use-disorder records, may require separate authorization and additional language. This general form does not authorize their disclosure unless reviewed and completed under applicable rules.

I authorize only the specifically identified disclosure above

- ☐ I authorize

Acknowledgment / signature

Authorization to Release Information

Client full name

Client signature (type name if accepted by your secure e-signature workflow)

Date

Electronic signatures should be collected through an approved system that records consent and audit details.