



Comfort Therapeutic Services LLC
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Authorization for Release of Information

This Notice may be interpreted to you in other languages, if requested.

Today's date: _____ Client File #: _____

Client Last Name: _____ First Name: _____ Middle Initial: _____

Date of Birth: _____ Best contact phone #: _____ Home Cell Work

I hereby authorize to release information from my record as indicated below

Information Released From:	Information Released To:
Name/Clinic/Provider/Hospital, etc:	Agency Name:
Contact Name:	Staff Name:
Address:	
City/State/Zip:	City/State/Zip:
Phone #: _____ Fax #: _____	Phone: _____ • Fax: _____
Email: _____	Email: _____

I understand that the specific type of information to be disclosed includes:

<input type="checkbox"/> History and physical exam	<input type="checkbox"/> Treatment Plans Individual/Family
<input type="checkbox"/> Intake & Assessment (<i>incl. psych/med. History</i>)	<input type="checkbox"/> Coordination of Care Health Form
<input type="checkbox"/> Presence in Treatment (<i>admission/discharge dates</i>)	<input type="checkbox"/> Social Services Records
<input type="checkbox"/> Diagnostic Assessment/CMDE/ITP	<input type="checkbox"/> Drug & Alcohol Treatments Records
<input type="checkbox"/> Progress notes	<input type="checkbox"/> Mental/Behavioral Health Records
<input type="checkbox"/> Education/School Records /See client in school/IEP	<input type="checkbox"/> Coordination of Care Health Form
<input type="checkbox"/> Mental health treatment notes	<input type="checkbox"/> Social History Records
<input type="checkbox"/> Verbal Discussion	<input type="checkbox"/> Medical list / Problem List
<input type="checkbox"/> Psychiatric Evaluation, Treatment & Records	<input type="checkbox"/> Discharge Summary
<input type="checkbox"/> Psychological Evaluation/Assessment/Testing	<input type="checkbox"/> Other: _____

Information to be disclosed: BOTH verbal and written information

PURPOSE OF DISCLOSURE: Treatment/Service Planning Consultation/second opinion Continuation of care
 Legal School Insurance Ongoing Treatment
 Other (please specify): _____

Authorized Signatures:

 Parent/Legal Guardian/Authorized Person

 Relationship to client Date

 CTS Staff Signature and title

 Date