CHANGE WITHIN REACH
TOGETHER WE CAN MAKE CHANGE POSSIBLE

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION TO PROFESSIONALS

Name of patient: _____ Date of birth: _____

I understand that my records contain information about my therapy sessions and my mental health. I understand that all my records are protected by state and federal laws that require they are kept confidential and require my written consent to disclose.

I , _____, hereby authorize Change Within Reach, Inc. staff to exchange information with:

_____ _____

for the sole purpose of care coordination and provision of the highest quality of care.

I understand that I have the right to revoke this release at any time.

I have been informed and understand this authorization to release records and information, the nature of listed content that I am willing to release, and the implications of their release. This request is voluntary.

Signature of Patient (or authorized representative)	Patient Name (please print)	Date
Signature of Parent or Legal Guardian (if Patient is under 15)	Name of Parent or Legal Guardian	Relationship

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This is a confidential patient record.