Employee Assistance

Behavioral Health Programs

gup & ASSOCIATES, INC.

AUTHORIZATION FOR RELEASE OF INFORMATION

To: Name _____

Organization/Agency _____

Adress _____

City _____ State _____ Zip _____

Phone _____ Social Security No. (optional) : _____-____-_____

Client: _____ **Date of Birth:** _____

Purpose for Release: _____

Specific Information to be Released:

___ Results of Psychological Testing

___ Diagnosis

___ Treatment Plan

___ Statement of Progress

___ Prognosis

___ Discharge Summary

___ Recommendations for Current Treatment

___ Other: _____

I hereby request and authorize _____ to release _____ to obtain the above information regarding myself or my dependent, above named. This authorization is subject to revocation at any time at my written request; and unless otherwise specified hereinafter, it automatically expires one year from the date below. I relieve and release the above mentioned from any and all damages, claims, and causes of action arising out of, or in connection with the release of this information.

___ Please expect a telephone call from _____ to dicuss these matters:

_____

_____

Signature of Client or Legal Guardian _____ Date: _____

Fill out this form electronically or by hand and EMAIL to drgup@gupinc.com