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**AUTHORIZATION FOR RELEASE OF INFORMATION**

A separate form must be completed and signed for each agency and/or individual from whom information is being requested and/or to whom information is being released.

I give my permission for \_\_\_\_\_ to disclose my protected health information to

Independence Behavioral Coaching  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- to obtain information from:
- to release information to:

Agency/Organization: \_\_\_\_\_  
Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_  
Zip: \_\_\_\_\_

Regarding me or my minor child identified below:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ (Name) (Date of Birth)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

for the purpose of:  
\_\_\_\_\_  
\_\_\_\_\_

**To release the information specified on the back of this form.**

I understand that these records are protected under the Federal Confidentiality Regulations and cannot be disclosed without written consent. I certify that this consent has been given freely and voluntarily. I may revoke this authorization at any time, except to the extent that action has already been taken on this consent will automatically expire on the date and/or under the conditions specified below.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Witness**

\_\_\_\_\_  
Relationship to Client

\_\_\_\_\_  
Date

**\*\*Expiration Date:** This release is valid for six (6) months from this date of signing or as specified here (Define other conditions limiting expiration):