Growth Opportunity Center

Authorization to Release Information to a Third Party/Parties

Patient's Name:_____ DOB:_____ AGE:_____

I HEREBY AUTHORIZE GROWTH OPPORTUNITY CENTER, 928 JAYMOR RD, 8150, SOUTHAMPTON, PA 18966 TO DISCLOSE TO/RECEIVE INFORMATION FROM.

_____ _____

(Name of person and or entity) (Relationship to client)

_____

Address and telephone number of the person or entity to whom information will be disclosed.

I UNDERSTAND THAT THIS INFORMATION DISCLOSURE RELEASE WILL BE MADE FOR THE FOLLOWING PURPOSE:

- ☐ Coordination of Treatment
- ☐ Other _____

AND WILL BE LIMITED TO THE FOLLOWING SPECIFIC TYPES OF INFORMATION.

- ☐ Any applicable mental health-related information, including medications (If this box not checked, check all that apply):
- ☐ Appointment scheduling
- ☐ Session attendance
- ☐ Assessment testing reports
- ☐ Billing payment records
- ☐ Other_____

This authorization will expire on (check on):

Six months from date signed below

- ☐ Termination of treatment
- ☐ Other date or specific event_____

- I UNDERSTAND THAT I HAVE THE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION.
- I UNDERSTAND THAT, AT ANY TIME I HAVE THE RIGHT TO REVOKE THIS PERMISSION TO RELEASE
- INFORMATION. THE REVOCATION CANNOT APPLY TO RELEASES THAT MAY HAVE BEEN MADE PRIOR TO THE REQUEST TO REVOKE INFORMATION.
- I UNDERSTAND THAT THIS INFORMATION IS CONFIDENTIAL AND IS PROTECTED WITHIN THE BOUNDS OF HIPAA LAW FROM DISCLOSURE WITHOUT MY PERMISSION.
- I FURTHER UNDERSTAND THAT RELEASED INFORMATION MAY BE SUBJECT TO REDISCLOSURE BY OTHERS AND MAY THEN NO LONGER BE PROTECTED.

_____ Date_____

CLIENT SIGNATURE (AGE 14 AND OLDER)

_____ Date_____

PARENT OR LEGAL GUARDIAN (FOR ALL CLIENTS UNDER 18; CO-SIGNATURE REQUIRED FOR CLIENTS 14-17)

_____ Date_____

WITNESS (GOC provider or staff)

(For provider or staff only) Copy given to client_____ Copy offered but declined_____