Andrea and Associates, LLC
Therapy Collective

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Authorization to Exchange Confidential Information

Name: ______________________________

DOB: __________
or
SSN: ______________________________

I understand that the purpose for this release is to assist with my/this client's treatment by allowing communication between professional service providers or agencies and the important individual(s) in my/this client's life. To further this goal, I authorize two-way written and/or verbal communication between Andrea and Associates, LLC and the individual(s) named below. The specific information to be disclosed is selected from below. I understand that my records are protected under Confidentiality of Alcohol and Drug Abuse Patient Records; C.F.R. Part 2, and cannot be disclosed without my consent.

The information to be disclosed is to be initialed by the client:

___ Name of Clinician

___ Admission / Discharge Information

___ Treatment Compliance / Attendance

___ Treatment Plan Information

___ Summary of Progress

___ Discharge Summary

___ Discharge Planning

___ Results of Biological Monitoring

The information selected is to be disclosed only to the person(s) listed below:

Name: _________________________________ Relationship: ______________ Phone: _______________

Address: ____ Email: ______________________________

I understand I may revoke this release at any time, except to the extent it has already been acted upon. This release will expire one year from the date signed, or under the following circumstances ____________________.

Client Name: _____________________________________ Signature: ____________________ Date: ________

Parent/ Guardian Name: ____________________________ Signature: ____________________ Date: ________

Witness Name: ____________________________________ Signature: ____________________ Date: ________