Cate Richardson-Henley, LCSW-R
P.O. Box 36
Milford, NY 13807
Office phone: (607) 441-3088; Fax: (607) 441-3091

Release of Information – Medication Prescriber

Patient Name_____ DOB_____

Prescriber Name:_____
Prescriber Address:_____
_____
Phone:_____ Fax:_____

_____(check if you agree) I authorize Cate Richardson-Henley to release the following information for the purpose of coordinating my treatment with _____(Name of Prescriber coordinating treatment.).

_____(check if you agree) I further authorize _____(Name of Prescriber) to release the following information to Cate Richardson-Henley for the purpose of coordinating treatment.).

Information to be disclosed (check all that apply):
___Assessments/Evaluations
___Diagnosis
___Progress/Treatment Notes
___Treatment Plans
___Treatment recommendations
___Medication Information
___Discharge Summary
___Compliance with Treatment
___Relevant Medical Information
___Treatment Progress
___Educational information
___Information regarding my Drug and/or Alcohol Use
___HIV/AIDS information
___Correspondence concerning my treatment
___Any Relevant Clinical Information/Impressions
___Other_____

I understand that this is an optional (although recommended) form, which I am not required to sign.
I understand that this release can be revoked by providing Cate Richardson-Henley a letter requesting that it be rescinded. Ms. Richardson-Henley cannot be held liable for information released prior to the rescinding of this release.
This release is valid until discharge from treatment or as of the following date_____.

_____ Date:_____
Client's Signature