**Bussey Holistic Therapy**

95 Allens Creek Rd., Building 2, Suite 324

Rochester, NY 14618

(585)857-6081

**AUTHORIZATION FOR THE RELEASE OR EXCHANGE OF INFORMATION**

Patient/Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB: \_\_\_\_\_\_\_\_\_\_\_\_

I **do/do not** authorize Bussey Holistic Therapy to communicate in person, by telephone or in writing for the purpose of coordination of care with the agency or person listed below:

Practitioner/Agency Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information to be released or exchanged:

\_\_Medical History \_\_ Medication Records

\_\_ Psychiatric History \_\_ Psychiatric Assessment/Evaluation

\_\_ Psychological Assessment \_\_ Physical Exam/Assessment

\_\_ Progress Notes \_\_ Diagnostic Tests

\_\_ Social History \_\_ Discharge Summary

\_\_ Substance Abuse History \_\_ Alcohol Abuse History

\_\_ Legal History \_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

This consent will be effective for\_\_\_\_\_\_\_\_\_\_\_\_\_\_ from the date signed.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_