



AUTHORIZATION TO RELEASE / EXCHANGE INFORMATION

Coordination of Care | Better Outcomes | Your Permission, Your Control

1 PATIENT INFORMATION

Full Name: _____
Date of Birth: _____
Phone: _____
Address: _____

2 AUTHORIZED PERSON / ORGANIZATION

Name / Organization: _____
Contact Person: _____
Address: _____
Phone: _____
Fax / Secure Contact: _____

3 DIRECTION OF INFORMATION

- ☐ Horizon may release information to the person/organization above
☐ Horizon may obtain information from the person/organization above
☐ Two-way exchange of information

4 INFORMATION AUTHORIZED

- | | |
|--|---|
| ☐ Psychiatric evaluation / diagnostic information | ☐ Hospital / discharge information |
| ☐ Medication list / medication history | ☐ Appointment / attendance information |
| ☐ Treatment plan / progress information | ☐ Billing / insurance information |
| ☐ Laboratory / diagnostic information | ☐ Other |

5 PURPOSE OF DISCLOSURE

- | | |
|---|---|
| ☐ Continuity / coordination of treatment | ☐ Legal / administrative purpose |
| ☐ Primary-care coordination | ☐ At my request |
| ☐ Therapy / behavioral-health coordination | ☐ Other |
| ☐ Insurance / benefits | |

6 EXPIRATION & REVOCATION

Expiration date or event: _____

I understand I may revoke this authorization in writing except to the extent action has already been taken in reliance on it. Certain records may have additional legal protections.

7 PATIENT ACKNOWLEDGMENT

Patient / Representative Name: _____
Signature: _____
Date: _____
Relationship / authority if representative: _____