



Authorization For The Release Or Exchange Of Information

Patient Name: _____

I hereby authorize Anthony Gajkowski of Amplify Fitness Inc. to obtain information from or release / exchange information to or with:

Name _____

Address/Phone _____

Specific Information To Be Released Or Exchanged:

- | | |
|--|--|
| <input type="checkbox"/> History and Physical Exam | <input type="checkbox"/> Court/Agency Documents |
| <input type="checkbox"/> Family Systems Evaluation | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> Mental Status | <input type="checkbox"/> Nursing Notes |
| <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Treatment Plans |
| <input type="checkbox"/> Consultation Reports | <input type="checkbox"/> Psychological Test Results |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Educational Records |
| <input type="checkbox"/> Chemical Recovery History | <input type="checkbox"/> Therapist Orders |
| <input type="checkbox"/> Educational – Tests | <input type="checkbox"/> Dates of Hospitalization |
| <input type="checkbox"/> Diagnoses and Reports | <input type="checkbox"/> Crisis Intervention Reports |
| <input type="checkbox"/> Psychosocial Report | <input type="checkbox"/> Medical Records |
| <input type="checkbox"/> Lab Results | <input type="checkbox"/> Chiropractic Records/Assessment |

Other (specify) _____

This release will continue in effect unless revoked by me. I understand that this release may be revoked by me, via request in writing, at any time except to the extent that information has been shared prior to my request to revoke this consent.

Client Signature

Date