AUTHORIZATION FOR RELEASE OF INFORMATION

Date _____
Name: _____
Date of Birth: _____

Patient Authorization
I hereby authorize the name(s) or entities written below to release verbally or in writing information regarding any medical, legal/court records, educational records, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the above identified patient. I authorize these agencies to share information by mail, phone, in person, fax and/or email contact. I understand that these records are protected by Federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

I hereby authorize _____

to speak to _____

All information will be held strictly confidential and cannot be released by provider without my written consent.

I may withdraw this consent at any time. If client is a minor child, I verify that I am the legal guardian/custodian of this child.

_____ _____
Signature of Client/Legal Guardian or Legally Authorized Representative Date

Sivan Rose Elefson, LMHC, R-DMT