Aaron Polsky, LCSW
1805 N. Mill Street, Suite B
Naperville, IL 60563

AUTHORIZATION TO RELEASE INFORMATION

Patient: _____

D.O.B. _____/____/_____

I/We authorize and request Dr. Kimberly A. Lemke, P.C., Mary Englund Psy.D.,LLC & Aaron Polsky, LCSW to release confidential professional information including personal, psychiatric, medical, laboratory, psychological testing data and interpretation, social, educational, substance abuse, clinical information, opinions, and/or any other information regarding his/her contacts with myself to:

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

PHONE: _____ **FAX:** _____

I/We also authorize and request the same above named person(s) to release any and/or said information to Dr. Kimberly A. Lemke, P.C., Mary Englund Psy.D.,LLC & Aaron Polsky, LCSW.

I understand that my refusal to consent to release the information specified above will prevent disclosure of such materials to the person/facilities named herein, with the potential consequence of reduced accuracy and completeness of my care.

The release is valid through _____/____/_____ unless dated as follows _____/____/_____

_____ _____

Patient Signature (if age 12 or older) Date

_____ _____

Parent/Guardian Signature Signature of Witness

**If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.