EMILY MARKOWITZ, LMSW LCSW

Psychotherapy

CONSENT TO RELEASE INFORMATION

This release of information form authorizes information from my records (or my child's record) to be shared between Emily Markowitz, LMSW, LCSW and the person or agency named below.

I give permission to Emily Markowitz, LMSW, LCSW to share information with:

_____

(Name of provider or facility)

_____

(Phone number of provider or facility)

or, I, the undersigned, authorize:

_____

(Name of provider or facility)

to release information about myself/son/daughter/ward, named below:

_____

Name Date of Birth

to Emily Markowitz, LMSW, LCSW:

The information to be shared is to be used for the purpose of conducting reviews of evaluations, treatment plans, discharge planning, and for the authorization of reimbursement. The information to be released includes as applicable: medical / psychiatric evaluations, treatment plans, progress notes, discharge plans and other information as specified below.

I understand that this authorization is valid for six months from the date listed below. I also understand that this information may not be released to any other person or organization without my permission in writing. A photocopy of this authorization shall be considered valid.

_____

Print Name

_____

Signature of Client or Parent/Guardian of Client Date