AUTHORIZATION FOR THE RELEASE OF INFORMATION

Laura Duke, LCSW, MSW

Client: _____Date: _____
DOB:_____

I authorize Laura Duke, LCSW

____ to release the information indicated below TO:
_____

____ to obtain the following information FROM:
_____

____ to exchange the following information with _____, on an ongoing basis for the duration of my treatment for the purpose of collaboration, evaluation, and/or treatment.

____ other:
_____

This release applies to the following information without regard to dates:

___ Medical and Social History

___ Diagnostic Evaluation/s

___ Psychological/Neuropsychological Testing ___ Treatment Summary (ies)

___ Discharge Summary (ies)

___ School Records

___ Other: _____

This information is released with the understanding that it is not to be rereleased, without my written permission, except as may be required by law. Such circumstances include, but are not limited to; suspected child abuse or neglect, elder abuse, situations of imminent physical danger to people or property.

In addition, I understand that these records may include information specifically regarding alcohol/substance abuse, which is protected by Federal Regulations (42 CFR Part 2).

I understand that this Authorization expires exactly one year after termination of this treatment unless specifically terminated by me in writing prior to that date.

Signature of Client: _____Date: _____

Signature of Witness: ____Date: ____________________