Maximize Wellness
Counseling & Coaching

Authorization Release Confidential Information

I (name of client)_____, authorize Cara Maksimow, LCSW, CPC of Maximize Wellness Counseling and Coaching to disclose and discuss mental health treatment information and records obtained in the course of psychotherapy treatment of Client, but not limited to, therapist's diagnosis of Patient to:

(Include all providers in client's treatment including medical doctor, psychiatrist, therapists, school providers, other pertinent professionals)

Name_____Phone:_____

Address: _____

Name_____Phone:_____

Address: _____

Name_____Phone:_____

Address: _____

I understand that I have the right to revoke this authorization at any time and that such revocation must be in writing and received by Maximize Wellness Counseling and Coaching at 10 Fairmount Avenue, Chatham NJ This authorization will automatically terminate when treatment with the client terminates.

This disclosure of information and records authorize by Client is required for the following purpose: continuity of care, referral for additional services, treatment coordination.

Client or Parent/Guardian Signature:_____

Print Name:_____

Date: _____