Nadine Durbach, MSW, LCSW
LCS 69911Private Psychotherapy Practice

RELEASE OF INFORMATION

NAME_____ADDRESS_____
DATE OF BIRTH_____PHONE _____

I _____, authorize _____, to release and exchange clinical information pertaining to my treatment consisting of the following:

Intake Assessment_____
Treatment Plan_____
Discharge Form/Summary_____
Other (please specify)_____

TO: NAME_____
ADDRESS_____
PHONE_____

This release is for the purpose of
_____
_____

The authorization shall expire on _____(Date)
If date is not entered, authorization shall expire one year after the signature date. This consent is subject to revocation at any time, except that said revocation shall have no effect with respect to information which has already been released in reliance upon this consent.

_____ _____
Patient/Guardian/Legally authorized Representative (Signature) Date

_____
Patient/Guardian/Legally authorized Representative (Print Name)

_____ _____
Witness (Signature) Date

_____
Witness (Print Name)

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulation (42 CFR-part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A General Authorization for the release of medical or other information is NOT sufficient for this purpose.