Marni Millet, LCSW, CASAC
4309 East Genesee Street
Syracuse, New York 13214
marnimillet@marnimillet.com
315-480-7160

Name _____Date of Birth _____

Address _____

City _____ State _____ Zip Code _____ Phone Number_____

Client information to be released/obtained/exchanged with the following entity:

Name _____

Address _____

City _____ State _____ Zip Code _____

Phone Number_____ Fax Number _____

Information to be released/obtained/exchanged, check and initial each one if agreeing to:
□Presence in treatment
□Diagnosis
□Assessment/Evaluation
□Progress in treatment
□Discharge information including discharge summary

Purpose of the above:
□Referral to from/to other services
□Coordination of care
□Collateral
□Other _____

Signature of Client _____ Date_____

Signature of Provider _____ Date_____

This authorization lasts for one year after the date you sign it unless you enter a different date or expiration here: _____. This authorization may be canceled in writing at any time. A photocopy/fax of this authorization will be treated in the same way as an original. Your signature indicates that you have read and understand this form, and authorize release of your information as described above. I understand that I may refuse to sign this authorization and that refusal to sign will not affect treatment.

FOR THE RECIPIENT OF THE INFORMATION: If any of the requested records contain information regarding alcohol or drug abuse treatment, it may be protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further use or disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the use or release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.