



AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Re: _____ Date of Birth: _____

This is to authorize _____

to disclose and release any information, including psychiatric and psychological records, of the above-captioned individual to:

who is authorized to discuss indicated matters (as checked below) pertinent to the progress of the patient.

This information is considered instrumental to the ongoing evaluation and treatment of this patient.

Data particularly requested includes:

_____ Psychiatric Information	_____ Social Welfare Data
_____ Psychological Testing	_____ Rehabilitation Records
_____ Educational Records	_____ Legal Information
_____ Medical Information	_____ Other: _____

Date: _____

(This Authorization for Release is valid for the Period of one year from the above date.)

Signature: _____

Client

Relationship to Client

Witness

Date