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AUTHORIZATION FOR RELEASE OF INFORMATION

Name _____ Date of Birth _____
(Please Print)

I hereby authorize the release of below-identified information:

____ Treatment/Discharge Summary ____ Intake Assessment ____ Therapy Session Notes

____ Current Issues/Progress ____ Psychiatric Evaluation

Other: _____

This information is to be:

_____ released **from** Dr. Federman to the indicated second party.

_____ released **to** Dr. Federman from the indicated second party.

_____ exchanged **between** Dr. Federman and the indicated second party.

_____ I authorize the information to be transmitted by e-mail. Patient's initials: _____

(I understand that e-mail is not a secure means of communication and that Dr. Federman cannot insure that e-mail content won't be accessed or read by individuals other than the named recipient.)

Second party: Name: _____

Address: _____

_____ e-mail: _____

Phone: _____ fax: _____

This information is to be released for the following purpose:

____ Treatment Planning, ____ Treatment Coordination, ____ Facilitation of Referral

Other:_ _____

I authorize the release of information for the following dates: ____ All dates of contact

____ Other (specify date or date range): _____

This authorization of release pertains only to the above-specified information and to the above-specified parties. I also understand that I may revoke this authorization at any time in writing except to the extent that Dr. Federman has already taken actions in reliance on it, and that the authorization will remain valid until revoked or upon expiration of one year from the date of this signed release.

_____ _____

Patient Signature Date