AUTHORIZATION FOR RELEASE AND/OR EXCHANGE OF INFORMATION

I understand that my records and information obtained during psychotherapy are confidential and protected under federal regulations and cannot be disclosed, exchanged or obtained without my written consent unless otherwise provided for in the regulations.

I also understand that I may revoke this authorization at any time, except to the extent that information based on this authorization has already been released, exchanged or obtained. This consent **will expire 12 months from the date signed** unless otherwise indicated below:
Other_____.

Information to be released, exchanged and/or obtained:
□ psychotherapy □ educational □ alcohol/drug
□ other _____

Specific information to be released, exchanged and/or obtained:
□ diagnosis □ dates of treatment □ treatment plan
□ treatment progress □ discharge summary □ summary of treatment
□ letters and correspondence □ complete records □ all pertinent information

Purpose:
□ facilitate treatment, coordinate services and assure continuity
□ assist in making referral
□ communication with insurance or managed care management
□ arrange leave of absence or return to work
□ comply with court order, subpoena, employer request, or other appropriate requests of information
□ other _____

When completed and signed, this document authorizes the release and or exchange of confidential information regarding the following client:

Client Name: _____Date of Birth: _____

Address:_____Telephone: _____

Treatment Dates: □ ongoing, or □ from _____ to _____

Between: Julie Ohlinger, MSW, LCSW, 10752 N. 89th Pl. Ste. 113, Scottsdale, AZ 85260 480-529-8680

And:

Name of Individual/Organization/Agency	Address	Telephone

_____ _____
Signature of Client/Parent/Legal Guardian Date

_____ _____
Witness Date