Consent and Authorization to Release Information

I : _____ DOB: _____

Request and Authorize:

Carol Baskin - Kacer, LCSW, LMFT

(name)

To release my medical records and or information concerning my medical records to:

_____

(name)

_____

(street)

_____

(city, state, zip code)

_____

(fax number)

Specific Extent of Information:

- ☐ Admission Record
- ☐ Discharge Summary
- ☐ Educational Evaluations
- ☐ Progress Notes
- ☐ Diagnosis
- ☐ Psychiatric Evaluations
- ☐ Psychological Tests
- ☐ Social History

Reason for Release of Information:

_____

(write reason here)

_____

I understand that I may revoke this consent at anytime; and in any event, it shall expire 90 days from date unless sooner revoked, but not retroactive to the release of information made in good faith; and further, that upon fullfilment of the above stated purpose this consent will automatically expire without my express revocation.

To the party receiving this information: This information has been disclosed to you from the records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclose of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

Signed:_____ **Date:**_____

Witness:_____

Legal Guardian:_____

(if under age 16)