Authorization to Release/Obtain Confidential Information and Records

Client Name: _____ Date of Birth: _____

I, _____, authorize and request that Laura Valentino, LISW-S, may release or exchange with, the client's confidential information, to the following individual, group, or organization, including insurance providers.

Individual, group, or organization name: _____
Address: _____
Phone number: _____ Fax: _____

Information to be released may include:

❏ Dates of treatment
❏ Treatment goals
❏ Progress in therapy
❏ Symptoms and/or diagnosis
❏ Other: _____

For the following reasons:

❏ Further enhance mental health treatment
❏ Insurance/billing purposes
❏ Communication between family members
❏ Provide requested information from other professionals
❏ Other: _____

This Release of Information is valid for one year from the date it was signed.

_____ _____
Client Signature (or parent/guardian signature, if applicable) Date

_____ _____
Clinician Signature Date