Authorization for release of information

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This release of information is limited to the person or agency named below and is not to be used for any other purpose than the one specified below.

I, _____, with the date of birth _____, authorize

(Client name) **(Client DOB)**

Elizabeth (Liz) La Colla, LSCSW to release, share and exchange the following professional information including assessment, progress notes, attendance, whether or not I am using therapy to my benefit, and if I am a risk to myself or others and recommendations as written records, by phone, in person, by mail and by fax.

☐ By e-mail ☐ I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.

Information may be shared with my insurance company as well as_____

_____

_____

For the purpose of

1.) Coordinating my treatment with my health care providers and also for consultation with other professionals that provider consults with.

2.) Insurance providers

2.) Protecting myself or others from harm

3.) Reimbursement for therapy.

4.) Patient request

I understand that my records are protected under state and federal confidentiality and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has already been taken. 1.) This release will remain effective until client's requests otherwise in writing.

Signature of Client _____

Date_____

Parent/ guardian signature if client is a minor_____