Authorization to Release and/or Request Client Information

Name ______________________________________ DOB ___________

Name ______________________________________ DOB ___________

Name ______________________________________ DOB ___________

Name ______________________________________ DOB ___________

Name ______________________________________ DOB ___________

This authorization will allow information to be released to and from Sharon Kocina and the following:

Name: ______________________________ Phone: _______________

Address: _____________________________ Fax: _________________

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Information exchanged with the above-named parties will be for the purposes of diagnosis, treatment, planning and coordination.

Specific information to be released may include diagnosis, length of treatment, summary of treatment, medical information and medications prescribed.

I understand that I may revoke this authorization at any time by written notice to Sharon Kocina, except to the extent that action has already been taken to comply with it.

Client Signature ___________________________________ Date __________

Client Signature ___________________________________ Date __________

Client Signature ___________________________________ Date __________

Client Signature ___________________________________ Date __________

Client Signature ___________________________________ Date __________

Parent/Guardian Signature __________________________ Date __________
(for client under 15 yrs. of age)