Authorization for Release of Information

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Client Name: _____ Date of Birth: _____

Address: _____

Phone: _____

I, _____ , hereby authorize Max Tsymbalau, MS, LMHC to

☐ *disclose information to* ☐ *receive information from*

Name: _____

Organization: _____

Address: _____

Phone: _____

Purpose of Disclosure:

☐ Continuity of care ☐ Legal purposes ☐ Other (please specify)

Specific Information to Be Disclosed:

☐ All treatment records ☐ Other (please specify)

I Understand that:

1. My records contain mental health information, and I give my authorization for these records to be released.
2. My records may contain information regarding mental health diagnoses, mental health treatment, chemical dependence treatment, as well as diagnosis and treatment of HIV/AIDS or other sexually transmitted diseases.
3. I may revoke this consent, in writing, at any time except to the extent that action has already been taken.
4. This authorization for release of information expires in 1 year, unless sooner revoked by me in writing.

Signature of Client: _____ Date: _____

Signature of Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____