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RELEASE OF INFORMATION

I, _____, whose Date of Birth is _____, authorize Sofia R.

Tuchapsky, RN, LMHC to ☐Release information to ☐Obtain information from ☐Exchange information with:

_____

(Name and Contact Information)

The information requested or authorized for release or exchange pertains to:

_____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. Unless sooner revoked, this authorization expires on the following date: _____ or as otherwise indicated:_____. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the provider above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my provider has no control over it and privacy laws may no longer protect it.

I will be given a copy of this authorization for my records.

_____

Patient's Name

_____ _____

Patient's Signature **Date**

_____ _____

Guardian's Signature (if patient is a minor) **Date**