

Materniak Counseling and Family Therapy

Becky Materniak, LPC, NCC
(636)542-1100
materniakcounseling@gmail.com

Authorization for Release of Information

Name: _____ DOB: _____

Address: _____ Phone: _____

_____ Email: _____

I authorize Materniak Counseling and Family Therapy to release information to and obtain information from:

Name of Provider or Facility _____

Address _____

Phone # (Include area code) _____

Email _____

PURPOSE OF REQUEST: Coordination of Care Support Other

TYPE OF RECORDS AUTHORIZED: Psychiatric/Psychological Evaluation and/or Treatment
 Dietetic Evaluation and/or Treatment
 Drug/Alcohol Evaluation and/or Treatment
 Other _____

SPECIFIC INFORMATION AUTHORIZED:

Assessments Progress Notes Laboratory Test Results
 Diagnostic Impression Discharge Summary Treatment Plans
 Treatment Summary Other: _____

I authorize the release and disclosure of the information described above with the individual or entity identified as often as necessary to fulfill the purpose identified in this document. My authorization will expire one year from the day this form was signed. I may cancel authorization at any time by submitting a written request, except where a disclosure was previously made in reliance on my prior authorization.

Patient Signature: _____

Date: _____

Witness Signature: _____

Date: _____