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Licensed Psychologist
_____
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# AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, authorize

Dr. Kathryn Berlá to: _____ obtain from and/or _____ release to

_____
(name and phone/fax numbers)

_____
(address)

The following information:
_____ANY information from records _____ Dates of Treatment

_____ Treatment Plan _____Admit and Discharge Summary

_____OTHER: _____

RE: _____
Self/Dependent's Name Social Security# DOB

I understand that this information is disclosed from confidential records protected by Federal law (42 CFR Part 2) and/or state confidentiality regulations. This authorization may be withdrawn at any time in writing except to the extent that the program or person which is to make this disclosure has acted in reliance on it. Upon revocation of consent, further release of information shall cease immediately. File copy is considered equivalent to the original. This authorization expires in thirty (30) or sixty (60) days following completion or termination of treatment, whichever is later.

_____
Signature Date

_____
Parent/Guardian Signature Date

TO THE RECIPIENT OF CONFIDENTIAL INFORMATION-PROHIBITION ON REDISCLOSURE: If the information disclosed to you is related to substance abuse treatment, this record's confidentiality is protected by federal law. Federal law (42 CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient to release substance abuse records. The federal rules restrict any use of the information to criminally investigate or prosecute any substance abuse patient. State law may also protect the confidentiality of patient's records.