Rachel Korenblit, LCSW, LLC

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Authorization for Release of Information

Patient Information

Name	Nickname/Maiden Name/Alias/Other	Last 4 Digits of SSN	
Address	City	State	Zip
Phone	Email	Age - Date of Birth (Mo/Day/Yr)	

I voluntarily authorize:

Name and Title of Treating Mental Health Care Provider or Other Party	Phone Number	Fax Number	
Agency/Department			
Address	City	State	Zip

To release my medical/mental health and/or assessment information to:

Name and Title of Treating Mental Health Care Provider or Other Party	Phone Number	Fax Number	
Agency/Department			
Address	City	State	Zip

The information to be released includes: (please initial next to checked boxes)

_____ ☐ **Mental health information/clinical notes**

_____ ☐ **Risk Assessment**

_____ ☐ **Verification of Attendance Only**

_____ ☐ **Other**_____

I understand that my authorization for the disclosure of this information is voluntary and I can refuse to sign this authorization. I also understand that my refusal to sign this authorization may result in the assessment process being terminated due to lack of essential collateral data.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of drug/alcohol diagnosis, treatment or referral information, and mental health information. I hereby authorize the above-named mental health care provider and/or agency to release any and all information deemed by the provider and/or agency to be relevant to this request to Rachel Korenblit LCSW LLC.

This authorization may be revoked at any time. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. Under federal law, no covered entity may condition treatment, payment, enrollment or eligibility for benefits on whether the individual signs this authorization.

_____ _____

Signature of Client (or Guardian) Date

_____ _____

Witness Signature Date