# Authorization for Release of Information

I give permission to Renee G. Felder, LCSW to exchange the following written and/or verbal information regarding myself (or my child) _____ with:

| Name | Phone Number |
|---|---|
| Name | Phone Number |

Check the items to be released:

____Diagnostic Assessment
____Treatment Summary
____Psychiatric Evaluation
____Psychological Evaluation
____Medical Records
____Other _____

____Drug & Alcohol Assessment
____Treatment Plan
____Discharge Summary
____Aftercare Plan
____Progress Notes

The purpose of this disclosure is _____

I understand that my records are protected under Federal Confidentiality Regulations, as well as the Pennsylvania Drug and Alcohol Abuse Control Act, and cannot be disclosed without my written consent, unless otherwise provided for in the Regulation.

This authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereon. This authorization will expire 180 days after the date of my signature or on _____ (if other than 180 days). The release of information is limited to the person or facility named above and will not be used for any other purpose than that stated.

I certify that this form has been explained to me and that I understand its contents.

_____ _____
Client's Signature Date Signed

_____ _____
Signature of Parent or Guardian (if applicable) Date Signed

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