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AUTHORIZATION FOR RELEASE OF INFORMATION

I, __________________________________, born on ___/___/_____, hereby authorize the release of information which may be acquired by Lifestyle Center for Counseling & Nutrition in a professional capacity to the following individual, agency insurance companies on my behalf:

____

Located at ____
(address, city, state, zip)

Phone: ______________________________

I, _____________________________, hereby authorize Mitzy Galer, LMHC (staff name)

my therapist/dietician (circle one), to disclose/obtain the following information from clinical records:

___ Entire record
___ Summary of treatment
___ History & Background
___ Complete treatment record
___ Educational record
___ Other: ________________________________

___ Diagnosis and dates of treatment
___ Psychological Evaluation
___ HIV status, if relevant
___ Substance abuse history
___ Legal information

about me/my child _______________________________________

for the following purpose: Treatment planning/ Continuum of Care

I agree that a photocopy of this release form is acceptable, and I understand that I have the right to receive a copy of the authorization form upon my request. I may revoke the consent to release information at any time. I also understand that any release of information which has been made before any revocation and which is based upon this authorization, shall not constitute a breach of my right of confidentiality.

________________________________ ___________________________________
Signature of client/guardian Printed Name

________________________________ ___________________________________
Authorization Date Witness

Relationship to Client: ___ Self ___Guardian ___ Parent of minor ___ Person legally authorized on client's behalf