

Authorization to Release Information

I, _____

authorize Kristen Berglund, MA, LPC-Intern and

(name of person(s) or organization(s) which disclosure is to be made to and/or received from)

to disclose or release **one to the other** the following information from my records:

____ All Health Care Information

Initials

____ Health Care Information or Opinions Relating to any or all of the

Initials following treatment(s) and, or conditions:

____ 1) Psychiatric or Mental Health Information

Initials

____ 2) Academic and Confidential School Information

Initials

____ 3) Testing

Initials

____ 4) Other

Initials

For the purpose of treatment/management and or supervision or psychological and or medical condition(s), **I hereby waive my right to the privileges of confidentiality as specified above, for a period of one year after termination of treatment, management or supervision unless expressly revoked earlier in writing.**

Patient

Date

Witness

Date