

Authorization to Release Information

I, _____ authorize Tabitha Intschert, L.C.S.W.,
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 (initial all that apply):

- _____ All Health Care Information
- _____ Health care information or opinions relating to psychiatric or mental health information
- _____ Health care information or opinions relating to confidential academic information
- _____ Health care information or opinions relating to testing or assessments
- _____ Other: _____

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 Signature: _____ Date: _____

Parent or Legal Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____