RELEASE OF INFORMATION AUTHORIZATION FORM

I authorize David Lechnyr, LCSW to use and disclose a copy of my Mental Health Information consisting of:

(Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Information
_____ Presence/Participation in Treatment
_____ Discharge/Transfer Summary
_____ Progress in Treatment
_____ Demographic Information
_____ Medication Records
_____ Other (Specify): _____

to/and or from the following person/organization:

Name/Agency (NOT your name): _____

Address: _____

Phone: _____ Email: _____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment, and when appropriate, coordinating treatment services.

Unless sooner revoked, this authorization expires in:
❑ 90 days ❑ One Year ❑ Other (Specify): _____

Client Rights and Acknowledgements:

- I understand that I have a right to revoke this authorization at any time by providing written notice to David Lechnyr, LCSW. However, the revocation will not affect any information that was already disclosed in reliance on this authorization.
- I understand that information disclosed under this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.
- I understand that I have the right to inspect and obtain a copy of the information to be disclosed.
- I understand that signing this authorization is voluntary and that my treatment will not be conditioned upon my authorization of this disclosure unless such authorization is necessary for the provision of treatment. However, it has been explained to me that failure to sign this authorization may have the following consequences: Interruption or delays in my treatment, difficulties in coordinating care among my providers, potential issues with insurance claims, and limited access to certain services.
- I understand that I am entitled to receive a copy of this authorization.

Client Name: _____ DOB: _____

Client Signature: _____ Date: _____