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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Client Name: _____ DOB: _____
Address: _____
City, State, Zip Code: _____

By signing this form, I authorize Stacy Rankin Greco, MSW, LICSW:
_____ To Disclose To _____ To Obtain From _____ To Exchange With

Name: _____
Address: _____
City, State, Zip Code: _____
Phone: _____ Fax: _____

The following information:
_____ Complete Record (May include reference to any or all areas listed below)
_____ Behavioral Health Record/Treatment Summary
_____ Psychiatric Record/Treatment Summary
_____ Chemical Health Record/Treatment Summary
_____ Medical/Medication Record/Treatment Summary
_____ Psychological Testing/Results
_____ Other _____

Purpose of Disclosure: _____

I understand that I may revoke this authorization in writing at any time. Revoking this authorization does not apply to information that has already been released under this authorization. This authorization will otherwise be considered valid for one year (12 months) from the date signed below.

To the Party Receiving this Information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.

Client: _____ Date: _____

Parent/Legal Guardian: _____ Date: _____