Authorization to Release Information

Name: _____ D.O.B._______________

I authorize Robin C. Bernhard to:
[ ] Release Information
[ ] Receive Information

Person and/or agency: _____

The information to be released/received is:
[ ] Admission and Disclosure Summaries
[ ] Intake
[ ] Progress Notes
[ ] Social History
[ ] History and Psychological Exam
[ ] History and Psychiatric Exam
[ ] Other: _____

The purpose of releasing this information is:
[ ] To Coordinate Services
[ ] To Inform Referral Source
[ ] To Comply With Court or Probation
[ ] Other: _____

Client (guardian): _____

Therapist: _____

Date: _____

Effective from this date until notified by client, or until treatment with this office has ceased.

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