Lisa A. Murawski, LMHC PLLC

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Williamsville, NY 14221
(716) 880-7089
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Authorization for Release of Confidential Information

This form, when completed and signed by you, authorizes me to release/receive protected information from your clinical record to/from the person or entity you designate.

I,_____ _____(Client Name & DOB)

_____(Parent/Guardian), authorize Lisa A. Murawski as well as her administrative and clinical staff to release/receive the following information pertaining to myself:

_X__Letter stating intake and session dates
_X__Intake Summary and Diagnosis
_X__Any information needed to obtain mental health insurance benefits
_X__Other (please be specific) _____Tx Planning_____

This information should only be released to/from (name and address of person or entity to which the information is to be released):

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

Primary Medical Doctor

I am requesting my counselor to release/receive this information for the following reasons:

_X__At my request
_X__To obtain mental health insurance benefits
_X__To coordinate treatment efforts
_X__Other (please be specific):_____Tx Planning_____

I have the right to revoke this authorization, in writing, at any time by sending such written notification to the above office address. However, such revocation will not be effective to the extent that this office has taken action in reliance on the authorization or if this authorization was obtained as a condition for obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my counselor generally may not condition counseling services upon my signing an authorization unless the counseling services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

_____ _____ _____ _____
Signature* of Parent/ Guardian Date Signature of Client Date

Print name: _____ _____ Print name: _____

**If a personal representative of the client signs this authorization, a description of such representative's authority to act for the patient must be noted.*