Lorie Bialobreski, LCSW
Licensed Clinical Social Worker Professional Corporation
Authorization to Release Health Care Information

Client name: _____ Date of birth: _____

Please release health care information to: _____

Provider Name: _____

Address:_____

City, State: _____ Zip Code: _____

Phone: _____ Fax: _____

Release the following information:

- Health care information relating to the following treatment or condition:

  _____
- Health care information for the date(s):

  _____
- All health care information:

  _____
- Other:

  _____

This authorization ends:

_____

I may cancel this authorization in writing as allowed by law. This would not affect any actions already taken based upon my original request. There are three ways to cancel this authorization:

(1) Sign and date a revocation form. This form is available from Lorie Bialobreski, LCSW; or
(2) Write, sign and date a letter to the Lorie Bialobreski, LCSW to cancel the authorization; or
(3) Sign, date and write "CANCEL" on this original form

Once the (clinician) gives out the information, the Lorie Bialobreski, LCSW has no control over it. The recipient might re-disclose it. Privacy laws may no longer protect it.

_____ _____

Patient or legally authorized individual signature Date

Relationship to patient if signed on behalf of patient_____