Vicki Klein, LCSW-C
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AUTHORIZATION FORM FOR RELEASE OF CLINICAL RECORD

This form when completed and signed authorizes me to release protected information from your (or your child's) clinical record to the person or institution you designate.

Patient Name: _____ DOB: _____

Address: _____

Phone: _____

I, _____, authorize Vicki Klein, LCSW-C, to communicate and share information with the person/people listed below:

I understand that Vicki Klein, LCSW-C, cannot re-disclose information she received from another health care provider if that health care provider requested that the information not be re-disclosed.
This information shall remain in effect for a period of one year from the date below or until_____.

The information is to be released to/released from:

Name: _____

Position:_____

Address: _____

Phone & Fax:_____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Vicki Klein, LCSW-C. I understand that no legal responsibility or liability of any nature shall attach to Vicki Klein, LCSW-C in acting upon this authorization.

Patient or Legally Authorized Individual Signature:_____Date:_____

Relationship to the patient if signed on behalf of the patient by parent, legal guardian, etc._____