Karen Chinca, LICSW
Psychotherapist

Authorization for Release of Confidential Information / Records

CLIENT NAME *Please print* ____________________ DOB ____________

I hereby authorize Karen Chinca, LICSW:

- ☐ to OBTAIN information regarding my care from the below named individual/agency
- ☐ to RELEASE information regarding my care from the below named individual/agency

The information may include:

- ☐ Telephone conversations regarding diagnosis and treatment
- ☐ Psychiatric evaluations and discharge summaries
- ☐ Medical Records
- ☐ Other ___________________________________

The individual / agency requesting / releasing information:

NAME ____________________ PHONE / FAX ____________________

ADDRESS ____________________

I have carefully read and understand the above statements and do hereby expressly and voluntarily consent to disclosure of the above information and/or medical records to those persons/agencies named above. This authorization may pertain to information related to alcohol and drug use/addiction.

I further release Karen Chinca, LICSW and any other individuals/agencies named from any liability arising from the release of information, provided the information is released in accordance with applicable law.

I understand that this directive is subject to revocation at any time upon written request. Otherwise this consent will expire one year from the date signed.

CLIENT / GUARDIAN SIGNATURE ____________________ DATE ____________