Karen Chinca LICSW

Authorization for Release of Confidential Information/Records

Client's Name: _____

D.O.B. _____

I hereby authorize Karen Chinca, LICSW: to disclose to and/or obtain from:

Name: _____

Address: _____

Phone/Fax: _____

The information may include:

___ Telephone conversations regarding diagnosis and treatment
___ Psychiatric evaluations and discharge summaries
___ Medical Records
___ Other _____

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

_____ _____
Witness Signature Date

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