Authorization for Release of Information

I hereby authorize: Dean Kirschner, PhD, LCSW-C
10635 York Road
Cockeysville, MD 21030
Phone 410-628-2121 Fax 410-666-7880

To Exchange information with:
(name and address): ________________________________
____
____
____

Pertaining to dates from _________________ to ________________________

Except for the following, which may not be disclosed (if none, write none): NONE

From the medical record of: ____
(name of client, date of birth and social security number)

For the purpose of: _________Psychotherapy_____________________________________

All information I hereby authorize to be obtained from this agency will be held strictly confidential and cannot be released by the recipient without my express written consent. I understand that this authorization will remain in effect for 1 (one) year unless I specify an earlier date here ______NONE_________________________.

I understand that the information used or disclosed may be subject to re-disclosure by the person(s) or class of person(s) receiving it and no longer protected by the federal privacy regulations. I understand that my confidential information may be released to the adoptive family in a non-identifying manner. I understand that I may withdraw this consent at any time as long as the request is made in writing to the above listed medical provider. However, I understand that if I revoke this authorization, it will not have an effect on action taken by the above medical provider in reliance on it before my revocation.

___________________________________ ________________________
Signature of Client or Legal Representative Date

____ ____________________
Signature of parent if client is under 18 years of age Date

Use this space only if client withdraws consent

_______________________________ ____________________
Signature of Client Date of revocation

A COPY OF THIS AUTHORIZATION SHALL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL