Elizabeth Matola, MSW, LCSW
Mindful Therapy & Consulting, LLC
13965 W. Burleigh Road
Suite 203
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(262) 391-8052
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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ Date of Birth _____

hereby authorize Elizabeth Matola, MSW, LCSW to: Exchange information with _____ Disclose to_____

Name_____

Address_____

City, State, Zip_____

Phone/Fax_____

For the purpose of: Continuity of care _____ Other _____

I understand the information in my health record may include diagnoses, prognosis, and/or treatment for mental illness, including alcohol and/or drug abuse.

The specific information to be released, obtained or exchanged:

____Assessments/Evaluations	____Discharge Summary	____Treatment Plans
____Progess/Therapy Notes	____Medication Notes	____All
____History/Physical	____Verbal Communication Only	____Other _____

Dates of Service Authorized to Release: All _____ Only the following dates_____

This consent will remain in effect until the following date or event_____and in all cases expires in one year from date signed.

I understand that I have the right to revoke this authorization at any time by submitting my revocation in writing to Ms. Matola. I understand that my revocation will not apply to information that has already been released as authorized, prior to notice of the revocation.

I understand that any disclosure of information carries with it the potential for an unauthorized disclosure and the information may not be protected by the confidentiality rules. If I have questions about the disclosure of my health information, I can contact Ms. Matola at 262-391-8052 or at the above address.

I have read all of the above and understand the nature of the release.

_____ _____
Signature of Client Date

_____ _____
Signature of Parent/Legal Guardian/Personal Representative Relationship