Lakewood Counseling

Paul Lehrer, LICSW, LMFT
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Authorization for Release of Confidential Information

Patient's Name:_____Date of Birth_____

I authorize Paul Lehrer, LICSW, LMFT to Receive Information From **and**/or Release To:

Name:_____

Address:_____

Phone:_____ Fax:_____

X Any and All Records OR ○ Selected Records:_____

X I also authorize written and verbal communication between the two parties above.

These records are required for the purpose of:

__**X**__ Continued/ Follow-up care _____ Social Service involvement

_____ Court/ Legal Action _____Claim payment/ Insurance Benefit Consideration

_____ Other _____

This authorization will remain in effect for one year from the date of signature and may be cancelled by me in writing at any time. I understand that such cancellation may be harmful to proceedings requiring records. I do not authorize re- release of this information to anyone. A photocopy of this authorization will be treated in the same manner as the original.

Signature of Patient:_____ Date:_____

Signature of Parent/Guardian:_____ Date:_____

DO NOT FORWARD TO ANOTHER PERSON OR AGENCY. Minnesota Govt. Practices Act (Chapter 328: H.F.738.S.F. 1213, 7/1/91, FEDERAL LAW VOLUME #40, PART IV, 71/1/75