Positive Change
for Teens and Families

AUTHORIZATION TO RELEASE INFORMATION

I authorize Karyn Feit, LCSW to disclose/exchange specific information/medical records related to the evaluation/treatment of: _____.
(Name of Client)

with the following individual/organization: _____.
(Name of Individual/Organization)

Specific information will include: (specify e.g. treatment progress, discharge):

_____.

I may revoke this authorization at any time except to the extent this action has been taken in reliance thereon. In any case, the authorization automatically expires one year from the date signed below.

Print Client Name:

_____ Date of Birth: _____

Client or Parent Signature:

_____ Today's Date: _____

Witness Signature:

_____ Today's Date: _____

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