AMY FANTALIS, LCSW & Associates
Building Bridges
42 East Front Street
Media, PA 19063
610-627-9060

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, (DOB:) authorize _____

___RELEASE INFORMATION

___OBTAIN INFORMATION

From:
_____
_____
_____
_____

___School Records & Reports ___Psychiatric Reports ___Psychological Reports

___Progress notes/report ___Discharge summary __Treatment summaries

___Medication information ___Medical info/status ___Exchange of information

___Progress in therapy ___Other _____

I understand that my authorization shall remain valid from the date of my signature, for a maximum of one year. I have been informed that I may revoke this authorization except to the extent that action has been taken in reliance thereon, by written or oral communication. I have also been informed of my right to inspect the information to be released and that all information will be handled confidentially.

I certify that this form has been fully explained to me, and that I understand its contents.

Signature of client: _____ Date:_____

Signature of Person Authorized in lieu of client (if under age 18): _____

Date: _____ Relationship to client: _____

Witnessed by: _____ Date: _____

Copy offered: _____ Accepted_____ Declined _____