

Elaine M. Iwanski, MFT
2428 K Street
Sacramento, CA 95816

Authorization for Exchange / Release of Information

Patient Name: _____ Date of Birth: _____

AUTHORIZATION:

I hereby authorize Elaine M. Iwanski who can be reached at (916) 446-8803 to exchange information with:

Name of Physician / Organization Phone

Address: Street City State Zip

INFORMATION:

Dates of treatment: _____

Information to be released: _____
(Medical, Clinical, School Records)

Purpose for disclosing information: Treatment Evaluation

REVOCAATION:

This authorization expires on _____ unless revoked by me prior to that date in writing.
(Date)

(IF NO DATE IS SPECIFIED BY THE PATIENT, THIS AUTHORIZATION SHALL EXPIRE IN SIX (6) MONTHS.)

SIGNATURES:

(Date of Signatures)

Consent Signatures (Patient, Parent, Caregiver)

Relationship (signed by person other than Patient)

Witness

RELEASE OF ALCOHOL/DRUG INFORMAITON

I also consent to the release of any and all alcohol and/or drug abuse treatment records under the same conditions as outlined above. I understand that such information cannot be released without my specific consent.

Mail Requested Information To:

Date of Signature

Consent Signatures (Patient, Parent, Caregiver)

Relationship (signed by person other than Patient)

Witness

I understand I have a right to receive a copy of this document.