Authorization For Release Of Confidential Information
Primary Care Physician

- ❑ To:
- ❑ From: Nike Carli, CSWR
  5500 Main St. Suite 207
  Williamsville, NY 14221
  Phone: 716-633-6900 Fax: 716-633-6902

- ❑ From:
- ❑ To: ______________________________

Information to be disclosed (include printed name of client): ______________________________

Purpose: Coordination of treatment.

I hereby authorize the release of the above information from my record. I understand that the information to be released from my record is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time before it is released. I also understand that my consent to release information will expire:

- ❑ Upon discharge from treatment
- ❑ To: 90 days from this date

Signature of responsible parent, relative or guardian. If client is over 14 years of age and under 18 years of age, client must sign also.

____
Witness

Nike Carli, CSWR
Printed Name of Witness

____
Date

____
Signature of Client

____
Printed Name of Client

____
Date

____
Signature of Parent or Guardian

____
Printed Name of Parent or Guardian

____
Date

For Cancellation or Refusal Only

❑ I hereby cancel my permission to release information from my record to the person or organization whose name & address is:

____
____
____

____
Signature of Client

____
Printed Name of Client

____
Date

____
Witness

____
Printed Name of Witness

❑ I hereby refuse to give my permission to release information from my record to the person or organization whose name & address is:

____
____
____

Signature of responsible parent, relative or guardian. If client is over 14 years of age and under 18 years of age, client must sign also.

____
Signature of Parent or Guardian

____
Printed Name of Parent or Guardian

____
Date