Laura Smith, MSW, LCSW-C, LLC
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AUTHORIZATION FOR RELEASE OF INFORMATION

This form when completed and signed by you, authorizes me to release protected information from your clinical record to the person you designate.

Client's Name: ____________________________________ Date of Birth: _________________________

I, ____, authorize Laura Smith, LCSW-C to

___ Release from my record ___ Receive from my record

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(*Provide a description of the information you want disclosed on the lines above. Your description should be as specific and detailed as possible.)*

I am requesting that Laura Smith, LCSW-C, release information for the following reasons:

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I understand that Laura Smith, LCSW-C, cannot re-disclose information she received from another health care provider if that health care provider requested that the information not be re-disclosed.

This authorization shall remain in effect for a period of one year from the date below or until __________________________.

The information is to be released to/released from:

Name: ____ Position:_________________________

Address:____

Phone:____

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Laura Smith, LCSW-C. However, the revocation will not be effective to the extent that action taken in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of the information and no longer protected by the HIPAA Privacy Rule.

Client/Guardian Signature ____ Date: ____________________