Danielle Roginski, LCSW
420 South State Road 7, Suite 118
Wellington, FL 33414
(561) 779-6711

AUTHORIZATION TO RELEASE/RETRIEVE INFORMATION

NAME OF CLIENT: ______________________________ DATE OF BIRTH: _____________

I authorize, Danielle Roginski, LCSW, to release or retrieve mental health information obtained in the course of psychotherapy treatment, including, but not limited to, diagnoses, to/from:

NAME: ____

ADDRESS: ____

____

PHONE NUMBER: ____

FOR THE PURPOSE OF: ____

____

TYPE OF INFORMATION REQUESTED OR RELEASED: ___________________________

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I understand that I have a right to receive a copy of this authorization. I understand that I have the right to revoke this authorization at any time unless therapist has taken action in reliance upon it. Revocation must be in writing and received by Danielle Roginski, LCSW, 1035 SR 7, Suite 315-06, Wellington, FL 33414.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the HIPAA Privacy Act or any other federal or state law.

Therapist shall not condition treatment upon client signing this authorization, and client has the right to refuse to sign this form. This authorization shall expire six months from the date treatment is terminated, unless revoked upon written notification by the signatory or client.

CLIENT: ____ DATE: _______________

EMPOWERED REPRESENTATIVE: ________________________ DATE: _______________

WITNESS: ____ DATE: _______________