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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Clarice Wirkala, PhD, LMHC, to:

- [ ] Release information to
- [ ] Obtain information from
- [ ] Exchange information with

Name

Address Phone

The information authorized for release or exchange is limited to the following:

- [ ] All relevant clinical information including diagnosis and treatment for _____
- [ ] Summary of treatment for _____
- [ ] Psychological/Psychiatric evaluation of _____
- [ ] Hospital admission/discharge summaries for _____
- [ ] Other: _____

This authorization is for the following purpose(s):

- [ ] Diagnosis and treatment
- [ ] Coordination of care
- [ ] Other _____

This authorization is valid for _____

This authorization may be revoked at any time by putting the request to do so in writing.

The information released as a result of this authorization may be subject to re-disclosure by the receiving party.

_____ _____
Patient Name Patient Date of Birth

_____ _____
Patient/Guardian Signature Today's Date