ALLISON SPLAUN, PH.D.

ADULT, CHILD, AND FAMILY THERAPY

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize the release of the information identified below:

__ All treatment records __ Diagnosis and Dates of Treatment __ Intake Report
__ Treatment Summary __ Current treatment issues/progress __ Billing information
__ Permission to verbally release relevant treatment information (includes diagnosis, dates of treatment, and procedure codes)
__ Other information: _____

This information is to be:
__ Exchanged **between** Dr. Splaun and the indicated second party.
__ Released **from** Dr. Splaun to the indicated second party.
__ Released **to** Dr. Splaun from the indicated second party.

__ I also authorize information to be transmitted by e-mail.

Second party:
Name: _____
Address: _____
Phone number: _____

This information is to be released for: __ Treatment Planning/Coordination
__ Facilitation of Referral
__ Other: _____

I authorize the release of information for the following dates:
__ All dates of contact __ Other (specify date range): _____

This authorization of release pertains only to the above-specified information and to the above-specified parties. I understand that I may revoke this authorization at any time, except to the extent that Dr. Splaun has already taken actions in reliance on it. This authorization will remain valid until revoked or upon expiration of one year from the date of this signed release.

Client: _____ _____ _____
Print Name Signature Date

Guarantor (if the client is under 18, indigent, or assigned a legal guardian):

_____ _____ _____
Print Name Signature Date