Beth Lorell, LCSW, MPH

Authorization to Release Protected Health Information

Client Information:

Last Name _____ First Name _____ MI _____

DOB:_____/_____/_____ Email Address: _____

Address _____

Home Phone: _____ Cell Phone _____

I, _____, hereby authorize Beth Lorell, LCSW, MPH
Client Name

located at 444 Community Drive, Suite 207, Manhasset, NY 11030 (917-449-8128) to communicate with:

Name of person/facility to receive medical information: _____

_____

Address: _____

Phone: _____ Fax: _____

Type of Communication:

- ☐ Release information
- ☐ Receive information
- ☐ Exchange information

Purpose of Information Release:

- ☐ Further mental health evaluation
- ☐ Mental health treatment/care planning
- ☐ Other _____

This authorization is valid from _____ to _____.

I understand that I may revoke this consent at any time by giving written notice to the person or organization making this disclosure.

Client Signature: _____ Date: _____

Witness Name/Signature: _____ Date: _____