

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: _____