BARBARA NADALINI PRIESNITZ, MA, LPC
PSYCHOTHERAPY & HYPNOSIS

AUTHORIZATION TO RELEASE CONFIDENTIAL RECORDS OR INFORMATION

Client Whose Records/Information Should Be Released: (Name)	
Client DOB (date of birth):	
Who is authorized to release the confidential information?	Barbara Nadalini Priesnitz, MA, LPC
Who is authorized to receive the confidential information? (Name / Phone, FAX or Address)	
What should be included in this Authorization to Release Confidential Records or Information?	□ Phone Conversation Only to Discuss Client Progress (no docs) □ Progress Notes (electronic) □ Attendance Records (electronic) □ Payment History (electronic) □ Other
If Other, please specify:	
What is the purpose of this Authorization to Release Confidential Records or Information?	□ Additional Evaluation, Treatment or Care □ Transfer of Care □ Coordination of Care □ Other
If Other, please specify:	
The released information should be limited to this time period, topic, aspects of condition or treatment:	
This Authorization to Release Confidential Records and Information has been explained to me by my therapist, Barbara Nadalini Priesnitz, and I understand the consequences and implications of the release of such confidential records and information. This authorization is entirely voluntary on my part. I understand that I may take back my Authorization at any time, except to the extent that action based on this Authorization has already been taken. This Authorization will expire automatically after one year from the date it was signed, or upon fulfillment of the purposes stated above.	
Signature of Client or Parent	
Printed Name	
Date	

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