Malia Parecki, LCSW

Release of Confidential Information

This authorization must be dated & signed by the client or their representative.

Regarding (Client Name) _____

Birthdate _____

I will authorize Malia Parecki, LCSW to:
_____ release information to and/or _____ receive information from

_____
(Person/organization)

_____
(Address)

_____
(Phone Number) (Fax Number)

Information will be used on my behalf for the following purpose(s):
____ Diagnosis & Evaluation ____ Treatment planning
____ Facilitation of ongoing treatment ____ Coordination with other service providers

By Initialing the spaces below, I specifically authorize the release of the following medical / mental health records. Please initial either yes or no for each item below.

Yes No
_____ _____ Social, medical or psychological reports
_____ _____ Treatment goals and results
_____ _____ ****Information about drug and/or alcohol abuse**
_____ _____ ****HIV/AIDS related records**
_____ _____ Other (please specify): _____

This authorization may be revoked at any time, in writing.
Unless revoked earlier, this consent will **EXPIRE 365 DAYS** from the date of signing.

*****This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulation (42 CFR, part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Federal regulation also restricts any use of the information to criminally investigate or prosecute the client.***

Client signature Date

Malia Parecki, LCSW Date