RELEASE OF CONFIDENTIAL INFORMATION FORM

Pursuant to the Confidentiality of Medical Information Act, we are required to obtain your specific authorization to disclose to appropriate parties any information regarding your diagnosis and/or treatment.

I, _______________________ authorize a reciprocal exchange of information between Eva Moheban, LCSW and ________________________ regarding my mental health treatment, diagnosis, and relevant information regarding progress. This disclosure of information and/or records is required for the following purpose:

____

____

The Authorization shall remain valid during the following dates:

___________ to ____________ .

Client Name: ___________________ Date of Birth: ________________________

Client Signature: __________________ Clinician Signature: ___________________

Date of Authorization: ____