

Authorization to Release and Exchange Information

Client Name _____

Parent/Guardian Name (if applicable) _____

I hereby authorize **Elena Vladu** to release information and receive information regarding my or my child's condition and the progress of treatment with the provider below. I am hereby waiving any claim or privilege of confidentiality between these parties:

Third Party (Doctor, Family Member, etc) Information

Third Party Name and Title: _____

Provider Address: _____

Provider Phone: _____

Purpose of release and/or any limitations: _____

This release is effective from*: _____ to: _____

*If required for length of treatment, indicate to "end of treatment"

I have read the above release agreement. I am the client or the custodial parent/legal guardian of the child in treatment.

Signature _____ Date _____

Client or Parent/Guardian

Note: The person signing this authorization form has a right to receive a copy of this form as well as to revoke this authorization at any time by informing **Elena Vladu** and the named third party in writing.