Arthur J. Rosenbaum, M.S. Ed., LCSW-C
Clinical Social Work

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Authorization for Release of Medical Records

I, _____[Insert Name of Patient/Parent or Guardian] grant authorization to

Arthur J. Rosenbaum, LCSW-C to disclose to and/or obtain from:

_____ the following information regarding the
[Insert Name of Individual/Treatment Facility/School

treatment of _____[Insert Name of Patient].

Description of Information to be Disclosed

_____ Assessment and Diagnosis
_____ Psychiatric Evaluation
_____ Medication Management Information
_____ Discharge/Transfer Summary
_____ Progress in Treatment
_____ Academic/School Performance
_____Other_____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Arthur J. Rosenbaum, LCSW-C. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration

Unless sooner revoked, this consent expires on the following date: _____ or as otherwise indicated:_____

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Conditions

I further understand that Arthur J. Rosenbaum, LCSW-C will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may limit the continuity of care.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

I will be given a copy of this authorization, for my records, upon request.

_____

Signature of Patient/Client Date

_____

Signature of Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____

Signature of Witness Date

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