1320 South Frontage Road, Suite 200
Hastings, MN 55033-2481
651-500-0905
651-437-2616 fax
LutzTherapy.com

AUTHORIZATION FOR RELEASE OF INFORMATION

Client ______________________________ Date of Birth_______________

The undersigned hereby authorizes:

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____

____

To exchange information with:

____

1320 South Frontage Road, Suite 200
Hastings, MN 55033
Office 651-500-0905; Fax 651-437-2616

Information to be released:

_____ Diagnostic Interview
_____ Psychological Evaluation
_____ Discharge Summary
_____ Other (specify) ______________________________
_____ Progress Notes
_____ Verbal exchange of information

This information is to be released for the purpose of assessment, treatment planning and psychotherapy. This authorization can be revoked but not retroactive to the release of information made in good faith. The individuals and organizations named above are released from legal responsibility or liability for release of the above information to the extent indicated and authorized therein.

I understand that I may cancel this release at anytime by notifying the provider in writing. I understand the release will take effect on the date signed and will be in effect for one year.

_______________ Date

______________________________ Signature of Client's Guardian or Client

_______________ Relationship