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Authorization for Release of Information

I _____ hereby authorize Dr. Dara Querimit to release information, receive information, or exchange information about patient, _____ for the purposes of assessment and coordination of treatment to: _____

Phone Number OF OTHER PROVIDER: _____

Other Provider's Address: _____

_____

Specifically, I authorize the release of (please check all that apply):

_____ All relevant clinical data

_____ Intake and initial impression

_____ Intake, treatment course summary and diagnosis

_____ Other: (specify) _____

Authorization expiration date: _____

*****If left blank, the authorization will expire in one year from date signed.**

Signature _____ Date: _____