3622 Lyckan Parkway, Suite 3002, Durham, NC 27707
2310 S. Miami Boulevard, Ste 236, Durham, NC 27703
1042 Washington Street, Raleigh, NC 27604
Phone: (919) 602-6766
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AUTHORIZATION TO OBTAIN/RELEASE CONFIDENTIAL INFORMATION

Client Name_____ Date of Birth _____

I, _____ authorize:
(Client, or Parent/Guardian if client under the age 18)

- ❑ Clare A. Stadlen, LCSW, CEDS-S
- ❑ Eliza Sholtz, LCSW, CEDS-S
- ❑ Christine Pavey, LCSW
- ❑ Blair Marini, LCSW
- ❑ Kate Hanson, LCSWA
- ❑ _____

to obtain/release the following information pertaining to myself/child:

- ❑ treatment progress
- ❑ history/intake
- ❑ diagnosis
- ❑ medical records
- ❑ dates of treatment attendance
- ❑ discharge summary
- ❑ other
  _____
  _____
  _____

for the purpose of:

- ❑ treatment coordination
- ❑ other

_____

with the following individual:

Name _____

Address _____

Phone _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition or event _____.

I understand that medical records are confidential and will not be disclosed without my written consent. I understand that I may revoke my consent at any time, except to the extent that action has been taken in reliance therein. In consideration of this consent, I hereby release and hold harmless any of the parties named herein from any damages or legal liability related to the exchange of such information regarding my treatment and/or that of my minor child. I understand that I may revoke my consent at any time by informing all parties named herein, in writing.

Signature of Client _____ Date _____

Signature of Guardian (if applicable) _____ Date _____