Authorization for Release of Information

Pursuant to the "Confidentiality of Medical Information Act"

Client Information

Name | Birthdate | Social Security Number

Release Information

Release Addressed to:

Name/Title | Organization

Address

Phone Numbers

Type of Release:

- ❑ One-way Release — Allows party to whom the release is addressed to send requested information to Rakel Delevi, Ph.D., LMFT.
- ❑ Two-way Release — Allows party to whom the release is addressed and Rakel Delevi, Ph.D., LMFT to exchange information as specified.

Types of Information to be Released: ❑ Copy of Entire File ❑ Clinical Notes ❑ Clinical Summary

❑ Billing/Insurance Information ❑ DCFS/Other Reporting History ❑ Legal Case History

❑ Other:____

Specific Items Requested:

Purpose of Release: ❑ Treatment Planning/Facilitation ❑ Advocacy ❑ Facilitation of Benefits

❑ Other: ____

Limits of Release

Date Authorization Shall Be Valid Through | Other Limits

Signature

I have read, understand, and accept all of the above and have received a copy of this form.

Name (Print) | Signature | Relationship to Client | Date

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