MAUREEN POLIKOFF ACSW LCSW
505-750-8252
maureenpolikoff@gmail.com

AUTHORIZATION TO DISCLOSE AND RECEIVE INFORMATION

CLIENT NAME____ DOB________________

I hereby authorize Maureen Polikoff LCSW to:

__ receive information from and __disclose information to:

Name:____ and appropriate staff at:

Organization:____ Phone #______________

Address:____

Fax/email:____

FOR THE PURPOSE OF:____

Information to be disclosed:
__ Initial assessment
__ Family/Individual psychosocial evaluation
__ Treatment Plan
__ Progress and/or compliance with treatment goals
__ Compliance with GAL recommendations/Court Orders

Covering the period(s) from (date)_________ to (date)___________

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Maureen Polikoff ACSW. I understand that the revocation will not apply to information that has already been released in response to this authorization. Unless otherwise revoked, this authorization will expire one the following date, event, or condition_______________________________. If I fail to specify an expiration date, event, or condition, this authorization will expire one year from the date it was signed.

- I understand that once the above information is disclosed, it may be re-disclosed by the recipient, and the information may not be protected by federal privacy laws or regulations.
- I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to obtain services.

____
Signature, Client or legal representative (Relationship to Client)

____
Signature of Parent or Guardian (if client is under 13 years of age

____
Witness