AUTHORIZATION FOR RELEASE OF INFORMATION TO AN ATTORNEY

I authorize Alyssa Beer, LCSW, CFRC to disclose to and/or receive information only as stated below from the records of:

Client name: ______________________________________ DOB: ___________

Release to/from: ____

Address/Phone: __________________________________ Phone: __________________

__________________________________ Fax: ____________________

This may include:

- Mental Health Information
- Substance Abuse Information
- Physical Health Information
- Evaluations, Recommendations
- HIV Related Information
- Other (specify): _________________________

______ I understand that should I or my attorney require Alyssa Beer, LCSW, CFRC to appear in court or provide records, a subpoena is required and I will be asked to sign a consent form. Should I not be available to sign a consent form or refuse to consent to this, I understand a court order will need to be authorized by the Judge. I understand this is to protect my mental health records in accordance with the PA Code of Ethics 49.72 and the National Association of Social Workers.

By signing, I understand I have the right to revoke this Authorization at any time and must do so in writing. I may not revoke it to the extent that the Therapist has already relied upon it, or if the Authorization was signed as a condition of obtaining insurance coverage, or a continued court order/subpoena.

I have read this Authorization, or had it explained to me, and I understand it's contents.
I have ______ accepted ______ declined a copy of this release.

Signature: ________________________________ Date: ____________________

Print Full Name: ____________________________ Expiration Date: ____________

Witness: __________________________________

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