Seasons Therapy
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Authorization for Release of Protected Health Information

Client's Name:____

Parties disclosing/receiving information:

Provider: Ruth Dombrowski, LISW, DCSW, CACII, AASECT

Provider/Individual:____

Contact Information:____

Information to be released:
Dates of sessions:______
Diagnosis:______
Symptoms:______
Progress:______
Compliance:______
Discharge Summary:______
Other:____

Information will be used for continuation/enhancement of care.

I understand that I may revoke this authorization in writing to the provider/agency at any time except to the extent that action has been taken in reliance on it and that this consent shall expire one year from todays date unless specified as follows:_____________________________________

I understand that signing this authorization is voluntary and that my refusal to sign will not affect my ability to obtain treatment from the above providers.

Signature:____Date:___________________

Provider Signature:______________________________________Date:___________________

To the party receiving this information: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (42CFR Part 2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.