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RECORDS RELEASE AUTHORIZATION

I HEREBY GIVE PERLMAN COUNSELING AND SUPERVISION SERVICES LLC PERMISSION TO RELEASE RECORDS AND/OR DISCUSS ANY INFORMATION PERTAINING TO THE TREATMENT OF THE BELOW PATIENT. ALL MATERIAL IS DEEMED CONFIDENTIAL AND PERMISSION FROM PATIENT OR PARENT/GUARDIAN IS MANDATORY.

PERLMAN COUNSELING MAY RELEASE INFORMATION TO THE FOLLOWING:

NAME:______________________________

ADDRESS:______________________________

PHONE:____________________ FAX:____________________

I HEREBY AUTHORIZE ANOTHER MEDICAL PROVIDER:

NAME OF PROVIDER/FACILITY:______________________________

ADDRESS:______________________________

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TO RELEASE COMPLETE MEDICAL RECORDS IN THEIR POSSESSION WITH REFERENCE TO MY ILLNESS AND/OR TREATMENT DURING THE PERIOD:

FROM:____________________ TO:____________________

SEND MY MEDICAL RECORDS PERSONAL AND CONFIDENTIAL TO:

PERLMAN COUNSELING AT THE ADDRESS SHOWN ABOVE.

PATIENT NAME: ______________________________

ADDRESS:______________________________

SIGNATURE OF PATIENT OR

PATIENT REPRESENTATIVE:______________________________ DATE:____________