AUTHORIZATION TO RELEASE INFORMATION

I, ________________________________, authorize Sabrina Husain Bajakian,LCPC to

O Release information regarding my treatment to:

O Receive information regarding my treatment from:

Name ________________________________

Phone ________________________________

Agency ____

Address ____

For the following reason: ____
____

Material to be discussed: ____
____

I understand that my records are protected under Federal Confidentiality Regulations and cannot be disclosed without my written consent unless provided for in the regulations. I may revoke this consent in writing at any time. The revocation becomes effective once Sabrina Bajakian receives it in writing and does not pertain to information disclosed before the revocation. This consent is in effect for 6 months from the date it was signed unless specified otherwise below.

Date this authorization expires: ____________________

I agree to this disclosure information.

Client _________________________________ Date ______________

Guardian _________________________________ Date ______________
(if client is under age 15)

Witness _________________________________ Date ______________

Note to Recipient of Disclosed Information

This information has been disclosed to you from records whose confidentiality is protected under Federal Law. Federal Regulations (42CFR, Part 2) prohibits you from making any further disclosure of it without specific written consent from the person to whom it pertains, or as otherwise permitted by such regulations.