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Authorization to Release Information

Name: _____

Date of Birth: _____

Social Security Number: _____-_____-_____

I hereby authorize ____*Dr. Lilia Sheynman*_____ to (check one):

__X___ obtain from the following

__X___ release to the following

Name: _____Address:_____

_____ the following documents/information from the records pertaining to services received.

Dates of Service: _____

The documents to be released are described or listed as: _____

The records are required for the specific purpose of: _____*To coordinate treatment*___

I understand that my authorization will remain effective from the date of my signature for _*12 months*__, and that the information will be handled confidentially in compliance with all applicable federal laws.

I understand that I may see the information that is to be sent, and that I may revoke this authorization at any time by written, dated communication.

I have read and understand the nature of this release.

_____ _____
Signature of Client/Designated Representative Date

_____ _____
Witness Date