AUTHORIZATION to RELEASE CONFIDENTIAL INFORMATION to FAMILY MEMBERS

Patient: _____ Date of Birth: _____

Address: _____

Phone: _____

I understand that the purpose of this authorization is to assist with my treatment by improving communication between professional service providers and the important individual(s) in my life. To further this goal, I hereby consent and authorize The Serin Center to release the following information:

_____ Payment and/or scheduling information

_____ Report of findings

_____ Diagnostic information

_____ Summary of clinical sessions

_____ Any and all information necessary to assist with treatment planning and care

Consent is given for information to be released to the following family members:

_____	_____
Name of Person	Relationship to Patient
_____	_____
Name of Person	Relationship to Patient
_____	_____
Name of Person	Relationship to Patient

I understand that I may revoke this authorization in writing. I understand that once the information I have authorized to be disclosed reaches the noted recipient, that person or organization may re-disclose it, at which time it may no longer be protected under Privacy Laws. I hereby release The Serin Center, Dr. Serin and/or her staff receiving and/or communicating the records and results from any liability associated with the release of information. I understand this release will expire twelve (12) months from date of signature unless specified here _____.

_____	_____	_____
Patient or Parent Signature	Printed Name	Date

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