Julia A. Gladnick, LLC
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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL AND PROTECTED HEALTH INFORMATION

Client Name:____
Parent/Legal Guardian (if applicable):____________________________________
Address:____
City:_____________________________________ State:______________ Zip:___________
Date of Birth:_________________________________

I, ____ give authorization and permission to Julia A. Gladnick, LLC and Julie Gladnick, MA, LMFT to:

(Circle all that apply)
Release to Obtain from Exchange with

Name: ____
Address: ____
Phone: ____________________________________

The following specific information only: (circle all that apply)

Verbal summary and discussion of treatment	Record of attendance only	Evaluations/Testing reports
Treatment summary	Complete Medical/Mental Health record	Treatment plan
Diagnosis/Psychiatric conditions	Drug/Alcohol abuse information	Psychotherapy Notes

Other: ____

The purpose of this release is: (circle all that apply)

Coordination of care	Treatment planning	Legal issues
Testing/assessment	Condition of court order/parole	At the request of the client

Other: ____

I understand the following: *(See CFR §164.508(c)(2)(i-iii))*

- **This authorization will expire in one (1) year from the date of signing, unless otherwise specified here: ____.**
- **The disclosure of health information is voluntary and I have the right to refuse to sign this authorization.**
- **I have the right to revoke this authorization in writing at any time, except to the extent information has already been released in reliance upon this authorization, by providing written notice to the provider's address on this form.**
- **The information released in response to this authorization may be re-disclosed to other parties by the recipient, in which case it would no longer be protected by federal privacy regulations.**
- **Unless the purpose of this Authorization is to determine payment of a claim or benefits, my treatment or payment for my treatment cannot be conditioned on the signing of this authorization.**
- **If I have authorized the release of Drug or Alcohol conditions, Federal Law (42 CFR Part 2) protects the confidentiality of this information.**

____________________________ ____________________________ ________________

Client Signature Printed Name Date

____

Relationship to Client (if applicable)

Any facsimile, photocopy, or other reproduction of this authorization is authorization to release the requested information.