Lazaro Counseling Center, LLC
Authorization to Release Information

I authorize **Pushpa Chauhan, Psy.D.** to release to/obtain from (circle one or both):

Name of person or organization:_____

Address:_____

_____

Phone:(_____)_____Fax:(_____)_____

The information regarding myself:_____ or my child:_____

The information released will be limited to:_____
Social and/or psychological history, current symptoms and functioning, diagnostic impression, test results, reports, letters, consult, etc.

I am requesting my psychologist to release this information for the following reasons:_____

_____
Treatment coordination , referral, consultation, testing, psychological evaluation etc.

This authorization will remain in effect until _____ or 6 months from the date that I terminate therapy.

You have a right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

Signature:_____Date:_____
Patient, Parent, or Legal Guardian

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.