# **AUTHORIZATION TO RELEASE AND/OR OBTAIN CONFIDENTIAL INFORMATION**

## TO: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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This letter serves as authorization to release and/or receive from:

**Nyree Tchalikian, MSW, LCSW, CCTP**

**Integrative Positive Therapy**

**467 Springfield Ave.**

**Suites 201-202**

**Summit, NJ 07901**

Information regarding:

 School Records  Behavior Reports  CST Evaluation  Attendance Records

 Medical Records  Psychiatric / Psychological Evaluation  Discharge Summary

 Other (Please Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CLIENT NAME:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that this information is to be used for the purposes of ongoing evaluation and treatment, and that I may revoke my consent at any time.

**Authorization To Expire:** Upon Termination of treatment

**CLIENT SIGNATURE:\_\_\_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_

**PARENT/GUARDIAN:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_

**(if under 14 years old)**

**WITNESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_