Somatic Psychotherapy

AUTHORIZATION FOR RELEASE OF INFORMATION

Client's name _____ D.O.B. _____

I authorize **Fern Snogren, LCSW, MA, CTH** to (check which apply):

- ❑ **release information to**
- ❑ **receive information from**

Provider _____

Contact info _____

For the purposes of _____

Disclosure is limited to (please check which apply):

- ❑ Written information regarding the areas marked below
- ❑ Verbal information regarding the areas marked below
- ❑ Mental health assessment, diagnosis, treatment planning, and progress
- ❑ Case management
- ❑ Drug and alcohol assessment, diagnosis, treatment planning, and progress
- ❑ Medical diagnosis and treatment
- ❑ Psychiatric assessment diagnosis, treatment planning, and progress
- ❑ Other (specify) _____

I hereby voluntarily consent to the release of the above information. I understand that such information cannot be released without my consent, except in a medical emergency, per mandatory reporting laws or by court order. I understand that I have the right to refuse consent. I understand that I may revoke this consent at any time by submitting my request for revocation in writing. If I do not revoke it, this consent will expire one year after terminating treatment.

Client name (print) Signature _____

_____ Date _____