

# 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 \_\_\_\_\_