Dr. Christine Bielinski
COUNSELOR • COACH • SPEAKER • WRITER
(602) 399-4699 | christine@drchristinebielinski.com

AUTHORIZATION TO RELEASE INFORMATION

Client Name _____ Date of Birth_____

I authorize **Christine M. Bielinski, PhD, LPC** ☐ to release information to, AND ☐ to receive information from:

_____ _____
Name of Person Relationship

_____ _____ _____ _____
Street Address City State Zip Code

_____ _____
Phone Fax

The information to be released includes:

- ☐ Mental Health Records
- ☐ Diagnosis and Treatment Progress
- ☐ Treatment Plan
- ☐ Evaluations
- ☐ Other (Specify)_____
- ☐ Alcohol And/Or Drug Treatment
- ☐ Phone Consultation
- ☐ Medical/Health Records

The disclosure of information and records authorized by the above listed client will be used for the following purpose_____.

I understand I have the right to receive a copy of this authorization. I also understand that I have the right to revoke this authorization at any time and that in any case, it will expire one year after the date shown below. I certify that this authorization is voluntary, and I understand that I may refuse to sign this authorization. My treatment is not conditional to signing this authorization. I understand that by signing this release, I am waiving or partially waiving my privilege of privacy.

_____ _____
Client Signature Date

_____ _____
Witness Date