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AUTHORIZATION FOR RELEASE OF INFORMATION

To:
Name / Agency
Street
City
State Zip code
Phone Fax
I, (Print your name)_____

authorize Dr. Robert Benjamin and/or Lynn Benjamin, M.Ed., LMFT, CAADC to give and receive information concerning my (circle one or more) psychiatric/medical/psychological/addiction records and treatment to and from

_____,
at the above address. The information that may be released is limited to:

(Circle one or more): All clinical information /Medical information / Drug and Alcohol information /A specific report, letter, or test

The purpose is: (Circle one) Coordination of care /Discussion of a specific report, letter or test

My authorization shall remain effective for a period of one year from the date of my signature, and all information released will be handled confidentially. I may revoke this authorization (except to the extent that action has been taken in reliance thereon) at any time by written, dated communication to Lynn Benjamin, M.Ed., LMFT, CAADC or Robert Benjamin, M.D.

Thank you,

X_____ _____
Client signature Date

_____
Witness signature Date