

PSYCHOTHERAPY, ADDICTION, TRAUMA RECOVERY
MARK FALANGO
LCSW, CSAT

3 Village Square, Suite 13
New Hope, PA 18938
267.740.2962

RELEASE OF INFORMATION CONSENT FORM

Client Name(s): _____

Client Date of Birth: _____

Release of information from Mark Falango, LCSW, CSAT to Another Person or Party listed below.

I authorize Mark Falango, LCSW, CSAT to release/exchange the following information to:

Name: _____

Number: _____

Information to be Released:
(Please check)

- | | |
|--|---|
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Provider Records |
| <input type="checkbox"/> Assessment | <input type="checkbox"/> Coordination of Care |
| <input type="checkbox"/> Treatment Plans | |
| <input type="checkbox"/> Other (specify) _____ | |

I understand that this consent is subject to revocation by me at any time except to the extent that Mark Falango, LCSW, CSAT has already acted in reliance of this consent. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 180 days this consent automatically expires.

I understand that I have a right to receive a copy of this authorization.

Signature of client

Signature of witness to client

Signature of client's parent or guardian

Date on which client signed this document.