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Authorization for Release of Information

Patient name _____ Date of Birth_____

Date requested _____ (valid for 365 days unless otherwise specified)

I hereby authorize Katherine Esquivel, MS, LPC
☐ *to release* ☐ *to obtain* the following information from my testing, medical, and/or therapy record to/from:

Name:
_____
Address and/or phone number:
_____

Name:
_____
Address and/or phone number:
_____

Name:
_____
Address and/or phone number:
_____

I further understand that I may request to revoke or cancel this authorization at any time by notifying the doctor's office in writing. This authorization automatically expires in 365 days after date of request, unless revoked earlier or another date, event, or condition is specified.

I agree to release the above named and their agents, employees, and representatives harmless from all liability associated with the release of confidential patient information. I understand that the above named cannot be responsible for use or re-disclosure by a third party.

_____ _____
Patient/guardian signature Patient/guardian printed name

_____
Date