Karen Nam, LCSW (OR # L5719)

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Authorization to Exchange/Release Confidential Information

I, _____, hereby authorize *Karen Nam, LCSW* to exchange and/or release confidential information regarding my treatment with:

_____.
(Name & function of person (s) or entities that the information is to be exchanged/released – include contact #)

This Authorization permits the exchange or release of the following information:

_____ Diagnosis _____ Treatment Plan _____ Prognosis
_____ Progress to Date _____ Clinical Test Results _____ Dates of Treatment
_____ Patient Records _____ Summary of Treatment

_____ Any or All information necessary

_____ Other _____

I authorize the exchange and/or release of the information described above for the following purpose(s):

_____

_____

I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing.

This authorization shall remain valid until _____ or for one year from the date of this signature.

By: _____ Date: _____
(Client or Parent/Guardian if under age of 18*)

Minor: _____ Date: _____

*If signed by person other than Client, please indicate the relationship between Client and his/her representative: