Alyza Berman, LCSW
171 Village Parkway NE
bldg 8a
Marietta, Georgia 30067
(404) 694-0204

AUTHORIZATION TO RELEASE INFORMATION

Client Name: _____

Birth Date: _____ Social Security Number: _____

I REQUEST AND AUTHORIZE Alyza Berman, LCSW TO:

_____ Release To: _____ Request From:

_____
(NAME)

_____
(ADDRESS)

_____
(CITY/STATE/ZIP)

(PHONE) _____ (FAX) _____

Information released may include mental health privileged or confidential information, alcohol, drug or other treatment information. Certain communications are privileged and not subject to release without your consent under state and/or federal law.

After considering the above statement, I authorize Alyza Berman, LCSW to furnish information regarding my treatment to the above person or organization. I also agree to hold harmless Alyza Berman, LCSW from all liability that may arise from the release of information requested.

I understand that this authorization may be revoked by me at any time, except when information released in accordance with state or federal law.

_____ _____
Date Signed Client Signature

_____
Parent Signature/ (Legal Guardian if applicable)