Authorization to Release Information

Patient's name: _____ DOB:_____

I authorize Holly Cerny, LCMHC, to release and/or exchange information with:

_____

_____
(name & phone number)

I understand and agree that this Authorization will be valid and in effect for a year upon signature of this document. I understand that after that date, no more information can be used, exchanged, or released to the person or organization unless I sign a new Authorization.

I understand that I can revoke this authorization at any time per my written request.

_____
Printed name

_____

Signature & date