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AUTHORIZATION TO RELEASE AND/OR OBTAIN CONFIDENTIAL INFORMATION

I hereby authorize **Ravit Avni-Singer, MSW LCSW** to obtain _______and/or release______ confidential medical, school, and/or psychiatric information for the purpose of treatment planning and collaboration. This information may include HIV and substance use information.

This information exchange is regarding:

Client's Name:________________________________ DOB:__________________

TO/From:

____
name
____
address
____
phone and fax

I understand that this information will not be transmitted to anyone without my written consent or other authorization provided. I understand that I may revoke this consent in writing at any time, except to the extent that action has been taken in good faith on my consent. This consent expires automatically on the 30th date of the month following the end of treatment, or, unless otherwise indicated.

Client Signature:______________________________________ Date:_________________

Parent/Guardian if client is minor:____