

Maria P. Hanzlik, PsyD, HSPP
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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ do hereby consent and authorize Maria P. Hanzlik, PsyD, HSPP,

TO DISCLOSE to _____
Name/Address/Telephone Number

The following specific information regarding (self/child's name): _____

<input type="checkbox"/> Admission	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Attendance in Treatment	<input type="checkbox"/> Patient Demographic	<input type="checkbox"/> Psychological
<input type="checkbox"/> Progress in Treatment	Information	Evaluation
<input type="checkbox"/> Prognosis/Diagnosis	<input type="checkbox"/> Treatment Plans	<input type="checkbox"/> Other: _____

I understand that this information is to be used for the purpose of: _____

Patient/Guardian Signature

Witness Signature

Printed Patient/Guardian Name

Witness Printed Name

Date

Date

I, _____ do hereby consent and authorize Maria P. Hanzlik, PsyD, HSPP,

TO RECEIVE from _____
Name/Address/Telephone Number

The following specific information regarding (self/child's name): _____

<input type="checkbox"/> Admission	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Progress Notes
<input type="checkbox"/> Attendance in Treatment	<input type="checkbox"/> Patient Demographic	<input type="checkbox"/> Psychological
<input type="checkbox"/> Progress in Treatment	Information	Evaluation
<input type="checkbox"/> Prognosis/Diagnosis	<input type="checkbox"/> Treatment Plans	<input type="checkbox"/> Other: _____

I understand that this information is to be used for the purpose of: _____

Patient/Guardian Signature

Witness Signature

Printed Patient/Guardian Name

Witness Printed Name

Date

Date

Patients may revoke releases at any time by informing Dr. Hanzlik verbally or in writing. Unless otherwise specified by this patient, this release will remain valid for **1 year** from the time of signing.