Maria P. Hanzlik, PsyD, HSPP
50 E. 91st Street, Suite 316
Indianapolis, IN 46240
Tel: 317.550.3221
Fax: 317.550.3228

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:

___ Admission
___ Attendance in Treatment
___ Progress in Treatment
___ Prognosis/Diagnosis
___ Discharge Summary
___ Patient Demographic Information
___ Treatment Plans
___ Progress Notes
___ Psychological Evaluation
___ Other: _____

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

_____ _____
Patient Signature Witness Signature

_____ _____
Printed Patient Name Witness Printed Name

_____ _____
Date Date

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

TO RECEIVE from _____
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_____ _____
Patient Signature Witness Signature

_____ _____
Printed Patient 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.