Maternal Wellness Services
Counseling. Support. Resources.

AUTHORIZATION FOR EXCHANGE AND RELEASE OF INFORMATION

I authorize **Nicole Grocki, MS, LMFT, LCMFT**

And

Name: _____

Address: _____ Phone: _____

_____ Fax: _____

Email: _____

To exchange and release the following specific information:

To include the following: (check all that apply)

_____ Phone consult _____ Treatment plan/progress/recommendations

_____ Fax _____ Progress notes

_____ Email _____ Financial/payment information

_____ Assessment information _____ Attendance dates/times

_____ Any/all case information _____ Hospital records

_____ Other (specify) _____

In regard to: _____myself _____my child

Name: _____ DOB: _____

Name: _____ DOB: _____

For the purpose of: _____

Expiration date:_____
(maximum of one year from date signed)

This authorization is signed with the understanding that the information will not be passed on to anyone without my written permission, or be used for any other purpose than that specified above. Further, it is understood that I may withdraw this authorization in writing anytime prior to the expiration date.

_____ _____
Signature Date