Mark N Lazich, MS, LMHC
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Authorization for Disclosure of Healthcare Information

Client Name: _____ Birth date: _____/_____/_____ SS#:_____

Previous Name(s): _____ Address: _____

Treating Provider: _____

Information is to be disclosed to ☐ and/or received from ☐:

Name of Person/Agency: _____

Address: _____ Phone: (_____)_____
Fax: (_____)_____

For purposes of: _____evaluation _____treatment _____forensic assistance _____other: _____

I authorize Mark Lazich, LMHC to release my:

_____ General Mental Health Record

_____ Information related to chemical dependency/substance abuse

_____ Psychotherapy Notes (the private content of your conversations with your therapist)

_____ Information related to HIV/AIDS and/or sexually transmitted diseases

_____ Other: _____

I understand that I may revoke this Authorization at any time except to the extent that action has been taken in reliance on it, and that in any event this Authorization expires 12 months after the last dated signature.

_____ _____
Signature of Client Date

Parent/Guardian signature is required for all children under age 13. For children age 13 and over, we encourage the parent/guardian to sign, but it is not required. *I understand that the information being requested for the above named minor child may include information regarding myself, the parent/legal guardian, relevant to my child's condition and treatment. I consent to the disclosure of such information.*

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date

[12 Month Signature Updates]

_____ _____
Signature of Client/Parent/Guardian or Authorized Representative Date

_____ _____
Signature of Client/Parent/Guardian or Authorized Representative Date