Jodi Taub, LCSW
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AUTHORIZATION FOR RELEASE OF INFORMATION

I (We) authorize ____

(Facility/Provider)

____ to release

(Address)

____

(State specific nature of information to be disclosed)

from the clinical record of____ (____________)

(Name of client/recipient of mental health services) **(Date of birth)**

to Jodi Taub, LCSW, LLC 387 Park Avenue South, Fifth Floor, NY, NY, 10016 for the purposes of facilitating counseling/consultation and/or conducting an evaluation.

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to Jodi Taub, LCSW. I understand that a revocation is not valid to the extent that Jodi Taub, LCSW has acted in reliance on such authorization. This authorization is valid until one year from the signed date below.

It has been explained to me that if I refuse to consent to this release of information, the following are the consequences (specify, if any): __________ no information released and/or ___________

____.

A copy of this release shall have the same force and effect as the original.

_______________________________________ ____________________________________

(Client Signature 12 yrs. or older) (Date) **(Parent/Guardian Signature) (Date)**

_______________________________________ ____________________________________

(Witness) (Date) **(Relationship) (Date)**

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of this information unless the person who consented to this disclosure specifically consents to such re-disclosure. I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.