Rachel Schneider, LCSW

31356 Via Colinas #114, Westlake Village, CA 91362

(323) 452-5279 RachelLCSW@gmail.com

Authorization to Exchange/Disclose Information

I, _____ (D.O.B._____), give my authorization to permit **Rachel Schneider, LCSW**, to request and exchange **confidential** professional information with the following person/ agency:

Name:_____

Address:_____

Phone:_____FAX:_____

Information to be disclosed includes health information pertaining to my medical history, mental health or physical condition and mental health treatment received _____.
Initial

OR

Only the following records or types of health information (including any dates):

_____

_____

This protected health information is being used or disclosed for the following purposes:_____

_____

The authorization will expire on: ___/___/___. If I fail to specify an expiration date, this authorization will expire in six months.

I have the right to revoke this authorization in writing except to the extent that my therapist has acted in reliance upon this authorization. My written revocation must be submitted to Rachel Schneider, LCSW. In consideration of this consent, I hereby release Rachel Schneider, LCSW and the above named parties from any and all liability arising there from. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality laws (HIPAA).

Patient Name:_____ Patient Signature:_____

Date:_____

Therapist Signature:_____ Date:_____

Licensed Clinical Social Worker, # LCSW28427