

Eva Hudlicka, LICSW, MSW, PhD – Psychotherapy

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Authorization for Release of Information

Client name

Date of Birth

Authorization is hereby granted to Eva Hudlicka, LICSW to obtain or release information from / to (circle one or both)

Name of agency or other party Phone Fax Address

Name of agency or other party Phone Fax Address

Name of agency or other party Phone Fax Address

for the purpose of: treatment planning & coordination assessment other

Please check the types of information to be obtained / released below:

written records regarding intake diagnosis treatment plan discharge

neuropsychological assessment other (please specify)

telephone conversation to discuss client's care

I understand that I may revoke this consent in writing at any time. Unless previously revoked or unless an earlier date, event or condition of termination is specified, this consent automatically expires at the end of treatment.

Client

Date