PSYCHOTHERAPY, ADDICTION, TRAUMA RECOVERY
MARK FALANGO
LCSW, CSAT-S
3 Village Square, Suite 13
New Hope, PA 18938
267.740.2962

INFORMATION RELEASE AUTHORIZATION

I,_____, hereby authorize Mark Falango, LCSW, CSAT-S to:

_____(send) _____(receive) the following _____(to) _____(from):

_____

Other (specific person or organization): _____

_____

The specific type of information to be reviewed is:

☐ Information regarding assessment
☐ Information regarding treatment plan
☐ Information regarding level of care
☐ Information regarding authorized treatment
☐ Other (specify) _____

I understand that this consent is subject to revocation by me at any time except to the extent that Mark Falango, LCSW, CSAT-S has already taken action in reliance of this consent. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 180 days this consent automatically expires.

I understand that I have a right to receive a copy of this authorization.

_____ _____
Signature of client Signature of witness to client

_____
Signature of client's parent or guardian

_____
Date on which client signed this document