

MARK FALANGO

⊕ ASSOCIATES

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INFORMATION RELEASE AUTHORIZATION

I, _____, hereby authorize _____
of Mark Falango + Associates 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 + Associates 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