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

RELEASE OF INFORMATION CONSENT FORM

Client Name(s): _____

Client Date of Birth: _____

Release of information from Mark Falango, LCSW, CSAT-S to Another Person or Party listed below.

I authorize Mark Falango, LCSW, CSAT-S to release/exchange the following information to:

Name: _____

Number: _____

Information to be Released:
(Please check)

- ☐ Diagnosis
- ☐ Assessment
- ☐ Treatment Plans
- ☐ Other (specify) _____
- ☐ Provider Records
- ☐ Coordination of Care

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