Denise C. Wall, LCSW
610 Main Street | P.O. Box 514
Odessa, Delaware 19730
302-376-5259 Office
302-689-4474 Fax

Client Name: ________________________________

Date of Birth: ______________________________

AUTHORIZATION TO DISCLOSE INFORMATION (Please print clearly)

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and can not be disclosed with my written consent unless other wise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This release will automatically expire twelve months from the date signed.

I, ____ hereby authorize Denise C. Wall, LCSW:

Please check:

[ ] To release any applicable information to my Primary Care Physician and/or Insurance Company

[ ] To release billing information to the Insurance Commissioner's office, if necessary for insurance payment.

Primary Care Physician's Name: ____

Mailing Address: ____

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Patient / Client Signature: _________________________________ Date: ____________________

Signature of Client (or parent/guardian, if applicable)