Lisa Malek, LCSW-R
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585-732-8829ph 585-242-7881 fax

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I ______________________________ authorize Lisa Malek, LCSW-R to:

_X_ release to:
_X_ obtain from:
_X_ exchange with:
Excellus Blue Cross Blue Shield
P.O. Box 21146
Eagan, MN 55121
1-800-499-1275

the following information pertaining to myself or my child:

_____ treatment summary
_____ history/intake
_X_ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_X_ dates of treatment attendance
_____ education
_X_ other (specify) Insurance /Billing purpose

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) ______________________________

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event ______________________________. (See back for authorization extension).

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

____
Signature of Client Date

Social Security #: ______________
OR
Date of Birth: ______________

____
Signature of Child (over 12 years of age) Date

____
Signature of Witness Date