AUTHORIZATION TO RELEASE INFORMATION

I/We, ______________________________, hereby authorize Bobbi Nemovicher, LCSW to mutually exchange mental health treatment information and records obtained in the course of psychotherapy treatment of:

Patient____DOB______________with:

Name____

Address____

Phone______________________________Fax_________________________________

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing and received by Bobbi Nemovicher, LCSW at 675 Sierra Rose Dr. Suite 104; Reno, NV 89511 to be effective. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it.

Information that may be exchanged:

Educational/Academic Records

Educational Evaluation/Testing

Psychosocial/Diagnostic Assessment

Psychological Evaluation/Testing

Verbal communication with staff

Treatment Records

Psychiatric/Medication Records

Discharge Summary

History and Physical

Other________________________

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable California law may protect such information.

This disclosure/exchange of information is required for the following purpose:

*Treatment coordination*____

This authorization shall remain valid until one year after the date of signature.

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Signature of Patient, or Guardian Date

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Bobbi Nemovicher, LCSW Date