**AUTHORIZATION AND CONSENT TO RELEASE CLINICAL INFORMATION**

I hereby authorize Elizabeth Wittenberg, JD, LICSW, 3108 Hennepin Avenue South, Minneapolis, Minnesota 55408, to release to or exchange the following types of information with

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

concerning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ d.o.b. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

for the purpose of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

The following types of information, including information relating to mental health, may be released:

\_\_\_ 1. Presenting problem

\_\_\_ 2. Diagnosis

\_\_\_3. Professional impressions

\_\_\_4. Summary of treatment

\_\_\_5. Termination report

\_\_\_6. Complete case record

\_\_\_7. Other (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that the information released by this authorization will be protected as private data according to the provisions of the Minnesota Data Practices Act and, to the extent permitted by law, will not be released to others without my authorization.

I recognize that Elizabeth Wittenberg, JD, LICSW cannot guarantee the privacy of information she releases under this authorization, but it is my intent that the party I designate to receive it will consider it private according to the provisions of the Minnesota Data Practices Act.

I understand that I may rescind this authorization at any time by giving written notice to the parties and that otherwise it will expire on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. If no date is specified it will automatically expire one year from the date of my signature.

I understand the information above and my consent on this form is freely given.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature Witness

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

Legal Guardian, if minor