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# 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