

Jennifer L. Streit, LMHC
Release of Information Form

Regarding: Name: _____

Social Security #: _____

Date of Birth: _____

I authorize Jennifer L. Streit, LMHC to release written/verbal information regarding my mental health, psychiatric diagnosis, substance abuse information and any other information related to my mental health to the following individual/agency:

This authorization will remain in effect until ninety days from today's date. This information will be used for medication management.

Client

Date

Parent/Guardian