Authorization to Release Information

I, _____, the undersigned, give permission to Bina Roginsky, Psy.D. to release and provide information about to:

_____
(Name of provider)

_____
(Address)

_____
(Phone number)

_____
(Fax number)

The following information may be released (check all that apply):
❒ my diagnosis
❒ my treatment plan
❒ current and past medications
❒ information relevant to coordinating care
❒ when treatment is terminated and why
❒ other (please explain in detail) _____

I understand that that this release is valid for a period of one year. I further understand that I may revoke this
authorization at any time in writing. In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

_____ _____
Client or Parent signature Date

_____ _____
Bina Roginsky, Psy.D, BCBA Date