Lori A. Bonnevier, LCSW, LLC

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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with a custody and parenting time evaluation. I expressly request that the designated record custodian of all covered entities under HIPAA identified below disclose full and complete protected information to the following person(s) and institution(s) regarding myself or _____ to Lori A. Bonnevier, LCSW, LLC.

Professional/Agency/Relationship Address and Telephone/Fax Number/Email

_____

_____

My (self/child's/children's) date(s) of birth is (are):

_____

I understand and agree that the information will be used or disclosed by my placing my ***initials*** in the applicable space next to the type of information:

_____ Assessments
_____ Diagnosis
_____ Alcohol and/or drug treatment information
_____ Pertinent medical and/or psychiatric information
_____ Treatment plans, progress notes, and discharge summary
_____ Psychological evaluations
_____ Educational records
_____ Other information (please be specific)_____

For the specific purpose of: Custody and parenting time evaluation.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of drug/alcohol diagnosis, treatment or referral information or mental health information.

Any facsimile, copy or photocopy of the authorization shall authorize you to release the records requested therein. I have read this authorization and understand it. This authorization will expire ninety days from date of signature. I also understand this authorization may be revoked by me, in writing, at any time except to the extent that action has already taken place.

_____ _____
Signature of Client/Legal Guardian Signature of Witness

_____ _____
Date Date