Samantha Wakach LCSW
1923 ½ Westwood Blvd., Ste 4A
West Los Angeles, CA 90025
Tel: (310) 365-4295

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize Samantha Wakach, LCSW. to exchange information pertaining to my treatment with and/or release copies of my psychiatric and medical records to:

NAME OF PERSON OR TITLE OF ORGANIZATION

ADDRESS AND/OR PHONE NUMBER

The relevant and timely information that may be released is limited to:

☐ Initial Clinical Summary	☐ Verbal Telephone Contact
☐ Progress Notes	☐ Medication
☐ Laboratory Results	☐ Consultations
☐ Psychological Testing	☐ Other _____

These records are required for continuity of clinical care. This release will be valid until treatment ends, unless otherwise noted.

I certify that I have read this form and that I understand its contents. I also understand that I have a right to receive a copy of this authorization upon request.

_____ NAME (PLEASE PRINT)	_____ SIGNATURE
_____ DATE	