FRANZISKA RACKER CENTERS

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize Franziska Racker Centers to release and/or receive any evaluation reports, progress reports or other written communication and to discuss such information with the individuals and/or institutions listed below for **ONE YEAR** from date signed. I understand that information via electronic transmission (e-mail/fax) may not be secure. I understand that others may review my/my child's records in order to comply with municipal and agency compliance reviews. I understand that I may cancel my authorization at any time (but cannot be retroactive).

PLEASE PRINT

Patient Name _____ DOB _____

Parents/Guardian (if child): _____

Address: _____

Please send reports to the following:

Physicians:

Name: _____

Address: _____

Name: _____

Address: _____

Others:

Name: _____

Address: _____

Name: _____

Address: _____

SPECIAL INSTRUCTIONS: _____

_____ _____

Signature of patient/parent or guardian Date Signed

_____

Relationship, if other than patient

Revised 07/15