402 West Broadway
Suite 400
San Diego, CA 92101

Email Karen@therapyinsd.com
Phone 619-889-0662
Fax 888-974-1286

Kerschmann and Associates

I hereby authorize Karen Kerschmann, LCSW, to release or obtain information from:

_____

(specific name/person/contact info)

Regarding records obtained during the course of treatment of the below individual:

_____

(Client name and DOB)

The information being released includes relevant history, assessment, treatment records, and/or_____.
(specify nature/extent of additional information to be released)

The purpose of this release is to facilitate treatment.

- I understand that I may revoke this authorization at any time, except to the extent that action has been taken
- I understand that the information that may be disclosed may include substance and/or mental health treatment
- Federal law prohibits re-disclosure of this information by the recipient
- Minor clients and the parents/legal guardian must sign this Authorization
- A photocopy/fax of this authorization may be accepted in lieu of the original
- This release will expire 12 months after date of signature

Signature of Client (12 and over)_____

Date_____