RAVIT AVNI-SINGER, MSW LCSW
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AUTHORIZATION TO RELEASE AND/OR OBTAIN CONFIDENTIAL INFORMATION

I hereby authorize **Ravit Avni-Singer, MSW LCSW** to obtain _____and/or release_____ confidential medical, school, and/or psychiatric information for the purpose of treatment planning and collaboration. This information may include HIV and substance use information.

This information exchange is regarding:

Client's Name:_____ DOB:_____

TO/From:

_____
Name

_____
Address

_____
Phone and Fax

I understand that this information will not be transmitted to anyone without my written consent or other authorization provided. I understand that I may revoke this consent in writing at any time, except to the extent that action has been taken in good faith on my consent. This consent will expire one year after treatment has ended, or, as otherwise indicated.

_____
Client Signature and Date

_____
Parent/Guardian Signature if client is minor and Date