SARA MATHEWS DIXON
Psychotherapy

SMD Associates, LLC.

I authorize Sara Mathews Dixon, LCSW to obtain information from and/or release to:

Name:_____

Address:_____

Phone Number:_____

Fax Number: _____

The specific information to be released or exchanged is:

( ) Diagnosis
( ) Admission Assessment
( ) Progress in Treatment
( ) Recommendations
( ) Other _____

This information will be used for the following purposes:

( ) Evaluation and Continuing Treatment
( ) Coordination of Care
( ) Educational Placement/Educational Concerns
( ) Other _____

In order to disclose specific information related to HIV/AIDS status, Substance Abuse or Mental Health please initial the following:
HIV/AIDS _____
Substance Abuse_____
Mental Health_____

I understand that I have the right to revoke this authorization at any time, by submitting a revocation in writing to Sara Mathews Dixon, LCSW. The revocation will not apply to information that has already been released in response to this authorization. I further

28 Thorndal Circle / 3rd Floor
Darien, CT 06820; (O) 203.636.0080
www.smdpyschotherapy.com

understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

If the disclosure is for educational purposes, I understand that the recipient may be my child's home school district, any school with the home school district, and a school that my child attends which is funded by the home school district. Disclosures to any other school or educational entity requires a separate authorization.

I understand that authorizing the disclosure of this information is voluntary. I understand that I can refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I have a right to receive a copy of this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient, and the information may not be protected by the federal privacy rules.

I further understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

_____	_____
Signature of Client or Legal Guardian	Date
_____	_____
Signature of Witness	Date