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Patient Authorization for Release of Medical Information

I, _____, hereby authorize Nina Unger, RN, LCSW to release/obtain information in my records, including diagnoses, treatment information, and other notations, to/from _____. I also authorize _____ to discuss my treatment if appropriate. This released information may be solely used for purpose of clinical and medical treatment. This authorization is valid from _____ to _____.

Signed: _____

Dated : _____