Katarzyna Lesniak-Karpiak, Ph.D.
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AUTHORIZATION FOR COMMUNICATION OR RELEASE OF INFORMATION

I, _____
(Print Full Name)

hereby authorize the release of my/my child
_____**records or allow communication**
(name of the patient)

Between

Name: Katarzyna Lesniak-Karpiak, PhD
Address: 4 Park Plaza, Lower Level, Park Rd
City, State, Zip: Wyomissing, Pa 19610

And

Name: _____
Address: _____
City, State, Zip: _____
Fax:_____

Purpose of disclosure: _____

Information to be shared:_____

I give my permission for one year starting with the date of the first visits at the office of Katarzyna Lesniak-Karpiak, PhD, for the information listed above to be released to the above named requestor. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with laws. The requestor should not redisclose my medical record to another party without further written or verbal consent.

Date: _____ **Signature:** _____
(Patient or Legal Representative)