Katie Zezima McCabe, LCSW

Authorization for Release of Information

The purpose of this authorization is to improve the quality of my mental health treatment.

I hereby authorize Katie Zezima McCabe, LCSW, to:

Release information to / Obtain information from / Exchange information with

Name: ____

Address: ____

____

Phone: ____

Name: ____

Address: ____

____

Phone: ____

This authorization is valid for 1 year from the date below or ___________, (not to exceed 1 year). I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed, and dated request to Katie McCabe, LCSW, indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my therapist has no control over it, and privacy laws may no longer protect it.

Signature: ____

Printed Name: ____

Relationship to Patient: ____________________________ (self, parent, legal guardian)

Date: ____________________________ DOB: ____

3 Sylvan Road South Westport CT 06880 203.222.9528 katiemccabetherapy@gmail.com