

Authorization Consent and Release of Information

I, _____
Name

Street Address

City, State, Zip Code

Date of Birth

Telephone and Fax Numbers

Hereby authorize and/or request a release of information between Ivonne Garcia, LCSW and:

Person or Agency

Street Address

City, State, Zip Code

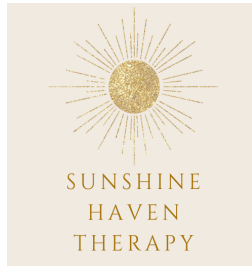
Telephone/Fax Numbers/Email

The specific information to be exchanged/released includes the following (as initialed by me):

You get to decide what to write here (e.g. all clinical content, information about risk, how many sessions I attended, general prognosis, diagnosis, treatment recommendations, etc.): _____

For the purpose of:

You get to decide what to write here too (e.g. coordinating care with other professionals, to help my family/friend/etc. know how to support me):



I understand that I can revoke this request and authorization at any time. I also understand that this authorization expires one year from todays date unless otherwise indicated by you and initialed here:
_____ (alternative date of expiration).

Printed Name of Client: _____

Signature of Client

Date