

WAIVER FOR RELEASE OF INFORMATION

I, _____ give my written permission for:
(Client's Name)

Stacy Telli, MSW, LCSW
Stacy R. B. Telli Counseling Services, PLLC
1930 North Salem Street
Suite 102
Apex, NC 27523
(919) 244-1145

To release information to:

(Name of Provider, Family Member, or Legal Representative)

(Address of Provider, Family Member, or Legal Representative)

(Phone, Fax & Email of Provider, Family Member, or Legal Representative)

Please briefly state anything you do not want released to this provider, family member, or legal representative (continue on back if necessary):

Please check in which way you wish for Stacy Telli, MSW, LCSW to communicate this information:

☐ Telephone

☐ Written (check which way you wish this to be sent)

☐ Send by traditional mail

☐ Email

Signature of Client & Date: _____

Signature of Witness & Date: _____