

RELEASE OF INFORMATION

_____ <i>Printed Name of Patient or Client</i>	____ M ____ F	____ / ____ / ____ <i>Sex Date of Birth</i>
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Maureen Newberg, L.C.S.W. has my permission to:

Verbally transmit
 Send
 Receive
 - the information checked below to/from:

Use a separate form for each person or agency with which information may be shared.

Initial all items covered by this release.

Collaborate in planning, providing, or coordinating services.
 Acknowledgment of receipt of services.
 Treatment Plan
 Psychiatric Evaluation
 Intake Assessment
 Progress Notes
 Diagnosis
 Psychological Evaluation
 Complete Record
 Other (specify) _____
 Other (specify) _____

This information is being shared for the purpose of: _____

This authorization is valid (check only one):
 Until Withdrawn

I understand that I can withdraw this consent at any time.

_____ Signature of Patient or Client	_____ Date
_____ Signature of Patient or Client	_____ Date
_____ Signature of Parent, Guardian, or other Authorized Person	_____ Date
_____ Therapist	_____ Date