AUTHORIZATION FOR RELEASE OF INFORMATION

To Our Clients
We can help you better if we are able to work with other professionals that know you and your family. By signing this form, you are giving permission for those listed to share information about your situation.

Name: _____ Date of Birth: _____

I authorize the following individuals or agencies to exchange information with Deborah Lyman, LCSW:

_____

_____

_____

_____

Purpose
The information received will be used to better serve in helping in planning and coordinating services for me and my family, or for other purposes, as specified:

_____

_____

_____

Only information necessary to assist in the process of my care will be exchanged. This permission is good for one year, or until _____

I can cancel this at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I understand that information about my case is confidential and protected by state an federal law. I approve the release of this information. I understand what this agreement means. I am signing on my own and have not been pressured to do so.

Client Signature _____ Date _____

Counselor Signature _____ Date _____

To Those Receiving Information Under This Authorization
This information disclosed to you is protected by state and federal law. You are not authorized to release it to any agency or person not listed on this form without specific written consent of the person to whom it pertains unless authorized by other laws.