

Gretchen D. Woosley, MSW, LCSW
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Authorization for Release of Information

I authorize: _____ Telephone _____

To disclose to: Gretchen Woosley, M.S.W., L.C.S.W. the protected information of

Name: _____ Date of Birth _____

Address: _____

Telephone: _____

I understand that the information will not necessarily include copies of the professional's original records, **but will involve the exchange of information by both parties** named above and relative to:

Summary of Social/Family History	_____
Summary of Psychiatric History	_____
Summary of Medical History	_____
Discharge Summary	_____
Psychological Testing	_____
Legal Issues	_____
Educational Issues	_____
Other (specify)	_____

This information is to be released for the purpose of therapeutic treatment, and I understand that I may revoke this consent at any time via written notice to the above noted practice.

Client or Guardian Signature

Date Signed

Relationship to Client if Guardian