Julia M. White, LCSW
Licensed Clinical Social Worker

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Authorization to Release Confidential Information

I, ____, hereby authorize
(Name of Provider or Facility) ____
to exchange confidential information regarding my/the client's treatment with Julia M. White, LCSW.

Client Information:
Name: ____
Address: ____
Phone: _______________ Birthdate: __________________________
Parent/Guardian (if applicable): _____________________________ __

This Authorization permits the exchange of the following information:

____ Any and All Information Necessary
____ Progress to Date
____ Patient Records
____ Diagnosis/Prognosis
____ Treatment Plan
____ Academic or Educational Records
____ Report of Teachers'/Staff Observations
____ Achievement and Other Tests Results
____ Psychiatric/Psychological Clinical Evaluation(s), Reports, Testing Records
____ Dates and a Summary of Treatment
____ Other:____

____

I authorize the exchange of the information described above for the following purpose(s):

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I understand that I have a right to receive a copy of this authorization. I also understand that any cancellation or modification of this authorization must be in writing. I agree that a fax copy of this Authorization will be valid.

This Authorization shall remain valid until: ____________________

____
Signature of Client Date

____
Signature of Parent/Guardian/Representative Date

If signed by other than client, please indicate your relationship to the client:

____