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AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT: _____DOB: _____

I AUTHORIZE: _____Cindy Crane, LCSW-C, 301.370.9794_____
(NAME)

TO RELEASE TO: _____
(NAME)

THE FOLLOWING INFORMATION:

___ VERBAL EXCHANGE

___ OTHER INFORMATION*

____ PARTICIPATE IN DEPOSITION

*** EXPLANTION OF OTHER INFORMATION:**
_____
_____
_____

I understand that I have the right to information about my treatment. I further understand that this information may not be disclosed without my authorization. This consent is valid for sixty (60) days and is subject to be voided by me in writing.

_____
SIGNATURE OF PATIENT/GUARDIAN DATE

_____
WITNESS DATE