



Tiffany Adams, LCSW
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Release of Private Health Information

Client Name:
DOB:
Client Address:

I give permission for Tiffany Adams, LCSW to release/receive information from:

Person or Agency:
Address:
Telephone Number:

The following information regarding the client/family: (check box)

Table with 2 columns: checkbox, text (Initial Assessment, Information on Progress in Therapy, Treatment Plan, Medical Information, Termination Summary, Other)

For the purpose of:

Table with 2 columns: checkbox, text (Coordination of Services, To Assist in Evaluation, To Provide Continuity of Treatment, Other)

I understand that I can revoke this authorization at any time, except to the extent that that action has already been taken. If not earlier expressly revoked, it shall expire one year from the date signed.

I understand that the specific type of information to be disclosed may include a history of DRUG or ALCOHOL, ABUSE or MENTAL HEALTH TREATMENT

Client Name Date

Parent/Legal Guardian Date

Witness Date