



Tiffany McPherson, LCSW
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Release of Private Health Information

Client Name:	DOB:
Client Address:	

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

Person or Agency:
Address:
Telephone Number:

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

<input type="checkbox"/>	Initial Assessment
<input type="checkbox"/>	Information on Progress in Therapy
<input type="checkbox"/>	Treatment Plan
<input type="checkbox"/>	Medical Information
<input type="checkbox"/>	Termination Summary
<input type="checkbox"/>	Other

For the purpose of:

<input type="checkbox"/>	Coordination of Services
<input type="checkbox"/>	To Assist in Evaluation
<input type="checkbox"/>	To Provide Continuity of Treatment
<input type="checkbox"/>	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