Warner Family Counseling
Kaylene Warner LCSW

Release of Information

I, _____ whose date of birth is _____ authorize Kaylene Warner LCSW to disclose and and/or obtain to/from _____. Whose contact information is as follows_____ _____.

Regarding:

__Assessment
__Diagnosis
__Psychological Evaluation
__ Medication Management
__Treatment Plan or Summary
__ Presence/participation in treatment
__ Medical Information
__Progress in treatment
__ Other

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.
IF other purpose specify_____

Expiration
Unless sooner revoked, this consent expires one year from date of signature.

_____ _____
Client Signature Date

_____ _____
Parent or Guardian Signature Date