DEBBIE GROSS, LCSW, Ltd.
3255 N. Arlington Heights Road • Suite 502 • Arlington Heights, IL 60004
Phone: (847) 253-5352 • Website: www.debbiegrosstherapy.com

AUTHORIZATION FOR RELEASE OF CLIENT INFORMATION

Patient Name:	Address:
Date of Birth:	City, Zip:

I authorize Debbie Gross, LCSW and:

Name: _____

Phone: _____

Fax: _____

Email: _____

to share the following information for the purpose of collaborative work:

_____*Treatment Summary* _____*Medication Management*

_____ *School Observations* _____ *Behavioral Interventions*

_____ *Clinical Observations* _____ *Family History*

_____*Other: _____*

I understand that my records are protected under HIPAA laws and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it and that in any event this consent expires automatically as described below.

Date:	Authorization valid through:
Client Signature:	
Parent/Guardian Signature:	