Elizabeth H. Pilson, LCSW-C

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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby give my informed consent to Elizabeth H. Pilson, LCSW-C

☐ Disclose information to:

☐ Obtain information from:

X Exchange information with:

Name: _____

Street Address: _____

City, State & Zip Code: _____

Telephone/Fax Number: _____

Regarding copies of and/or discussions related to the reports designated below and for continuing treatment.

☐ Treatment Summary
☐ Admission Assessment
☐ Psychological Evaluation
X Psychiatric Progress Note
☐ Therapist Progress Notes
☐ Treatment Coordinators Notes
X Psychiatric Evaluation

☐ Updated Primary Care Referral
☐ Social Service Progress Notes
☐ Discharge Summary
☐ Medical Information (Specify)_____
☐ Psychological Testing
☐ Pertinent Legal Documents
X Other (Specify) Medication Updates

Purpose of disclosure: **X** Assessment & Treatment ☐ Discharge Planning
☐ Other (Describe) _____

☐ Dependent

X Self

Patient Name: _____ Date of Birth: _____

Patient Address: _____

This consent will automatically expire one (1) year from the date signed by the patient, Guardian or legal representative and may be revoked in writing by the undersigned at any time.

_____ _____
Signature of Individual, Guardian, or Legal Representative (Seal) Date

_____ _____
Signature of Witness Date