BCSGroup
Brooklyn Women & Family Counseling Services LCSW, PLLC
Integrated Mental & Emotional well-being

## CONSENT FOR RELEASE OF INFORMATION

Client Name _____ DOB _____ SSN _____

Address _____

Name/Address of Person or Organization **Disclosing** Information

_____

_____

_____

Name/Address of Person or Organization **Receiving** Information

_____

_____

_____

Extent/Nature of Information to be Disclosed (be as specific as possible, e.g. discharge summary)

_____

_____

Purpose or Need for Information:

_____

_____

*I hereby authorize the release of the above information from my records. I understand that the information to be released from my records is confidential and protected from disclosure. I understand that my consent to release this information will expire in one year from this date. I also understand that I have the right to cancel my permission to release this information at any time before it is released.*

Client Signature _____ Date _____
*If parent or guardian, indicate relationship to client*

Signature of Witness _____ Date _____

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