Julia Clowney LICSW, LLC
475 N. Cleveland Ave, Suite 301
Saint Paul, MN 55104
Phone 651-797-4359 - Fax 888-971-4039

Authorization for Release of Client Information

Client name: _____ Client DOB _____

I authorize Julia Clowney LICSW to:

___ Exchange information with ____ Release information to

___ Obtain information from ____ Thank him/her for referral

Name/Agency _____

Address _____

Phone _____ Fax _____

Please check the following that apply to me/my child:

___ Brief summary of my records ___ Discharge summary ___ Medical records

___ Diagnosis ___ Social or family history ___ Progress Notes

___ Other: _____

The purpose of this information is:

___ Coordination of treatment planning ___ Evaluation

___ Other: _____

A photocopy of this release shall be effective for this purpose as the signed original. I understand that the information will be used for the purpose specified and will not be disclosed to other sources unless specifically authorized by law. I understand that I may refuse to release information or that I revoke my consent at any time. This consent will automatically expire one (1) year from the date of my signature, unless other conditions for expirations have been met at an earlier date.

_____ _____

Client printed name Witness printed name

_____ _____

Client signature Witness signature

_____ _____

Date of signature Date of signature