Cathy Swan, LCSW
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Release of Information

Please identify who you are allowing me to communicate with regarding your protected health information. ***This form must be signed, dated, and witnessed to be valid.***

I hereby authorize Cathy Swan, LCSW, to release my protected health information as listed below to:

Name of Person: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Please list any limitations to the information you are permitting me to release: _____

_____

_____

This authorization is valid for 1 year from the date of signature by the client or parent/guardian, unless another end date is indicated here: _____

_____

Signature of Client (Or Parent/Guardian) Date

Client's printed name, address, and phone number: _____

_____

_____

Witness Signature Date

Witness printed name: _____