Anne Drake, LCSW
COUNSELING AND PLAY THERAPY

Release of Protected Health Information

I, _____, authorize the release of Protected Health Information between the individuals listed below and Anne Drake, LCSW, for myself/my child _____.

School/Teacher: _____ Phone/Email: _____

Other Therapists

Name: _____ Phone/Email: _____ Therapy Type:_____

Name: _____ Phone/Email: _____ Therapy Type:_____

Other Individuals

Name: _____ Phone/Email: _____ Relationship:_____

Name: _____ Phone/Email: _____ Relationship:_____

For the purpose of: Planning and providing of social work services provided by Anne Drake, LCSW.

This authorization shall remain in effect until _____1 year from date of signature_____ at which time it shall expire, and no further release of information shall be made under these terms. I understand that I can revoke this authorization at any time by giving written notice. I also understand that I have the right to examine and copy the information disclosed.

_____ _____

Signature Relationship to Client

_____

Date