Gretchen D. Woosley, MSW, LCSW
3535 Randolph Rd. Suite 208
Charlotte, NC 28211
Phone: 704-365-1113

Authorization for Release of Information

I authorize: _____Telephone_____

To disclose to and/or obtain from: Gretchen Woosley, MSW, LCSW the protected information of:
Name: _____Date of Birth_____
Address: _____
Telephone: _____

I understand that the information will not necessarily include copies of the professional's original records, but will involve the exchange of information by both parties named above and relative to:

Summary of Social/Family History	_____
Summary of Psychiatric History	_____
Summary of Medical History	_____
Discharge Summary	_____
Psychological Testing	_____
Legal Issues	_____
Educational Issues	_____
Other (specify)	_____

This information is to be released for the purpose of therapeutic treatment, and I understand that I may revoke this consent at any time via written notice to the above noted practice. Unless revoked sooner, this consent expires on the following date:
_____.

I understand that Gretchen Woosley, LCSW will not condition my treatment on whether I give authorization for the requested disclosure. However it has been explained to me that failure to sign this authorization may have the following consequences:
_____

Unless you have specifically requested in writing that the disclosure be made in a certain format, I reserve the right to disclose information as permitted by this authorization in any manner that I deem to be appropriate and consistent with applicable laws, including, but not limited to, verbally, in paper format, or electronically. I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by HIPAA privacy protection regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protection. I have been offered a copy of this authorization for my records.

_____ _____
Client or Guardian Signature Date signed

_____
Relationship to Client if Guardian

_____
Signature of Therapist/Date