Uta Russell, LCSW
#LCSW65006
717 7th Street
Davis, CA 95616
(530) 400-4082
uta.russell.lcsw@gmail.com

Release of Information

I, ____ ____________________
Name of Client(s) Date of Birth

hereby authorize the release of confidential information regarding my treatment to be exchanged and disclosed between Uta Russell, LCSW, and the following person(s) or entities:

Name: ____

Address: ____

Phone: ____

Fax: ____

This authorization permits the exchange of the following information, including but not limited to symptoms, diagnosis, treatment plan, dates of treatment, summary of treatment, progress to date, prognosis, client records, other:____

I authorize the exchange of the information described above for the following purpose:

____

I understand that I have a right to receive a copy of this authorization per request. This consent shall become effective immediately and is valid for the duration of treatment, or until I revoke the consent regarding this release of information in writing at any time.

______________________________ ______________________________ ______________
Signature of Client or Client's Representative Name Printed Date

______________________________ ______________________________ ______________
Signature of Client or Client's Representative Name Printed Date

____ ______________
Uta Russell, LCSW Date

Copy given/sent to: ___Client ___Parent/Guardian ___Receiving Party (see above)