

LINDSAY SMITH, LCSW

Licensed Clinical Social Worker, Adolescent and Family Therapy

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**AUTHORIZATION FOR RELEASE OF INFORMATION**

I authorize Lindsay Smith, LCSW and:

Provider name: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

To exchange information about:

Client's name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Including, but not limited to, medical records, lab results, psychological testing, treatment history, diagnosis, medication records, school reports, etc. This information is to be used solely for the purpose of evaluation, diagnostic workup, treatment planning, and treatment.

This authorization has the following exceptions: \_\_\_\_\_

This authorization shall remain valid until \_\_\_\_\_  
or until a cancellation of this authorization is submitted in writing to this provider.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(client)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(parent/guardian)

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(parent/guardian)

\*Note: If parents are divorced or separated and have custody difficulties, both signatures will be needed.