Leslie C. Kilpatrick, M.Ed., LCSW, LLC
P.O.Box 204
Oakton, VA 22124
(703) 691-3578
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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize release of the below-identified information.
(Name of client)

☑ All treatment records	☐ Psychiatric Consultation	☐ Current Treatment Issues/Progress
☐ Intake Assessment	☐ Psychological Assessment	☐ Diagnosis/Dates of Treatment
☐ Case Notes	☐ Medication Summary	☐ Treatment/ Discharge Summary

Other: _____

This information is to be:

☑ Released *from* Leslie Kilpatrick to the indicated second party

☑ Released *to* Leslie Kilpatrick from the indicated second party

☑ Exchanged *between* Leslie Kilpatrick and the indicated second party

Second Party: Name: _____

Address: _____

_____

Phone: _____

This information is to be released for the following purpose(s):

☑ Treatment Planning ☑ Treatment Coordination ☑ Facilitation of referral

Other: _____

This authorization of release of information pertains only to the above-specified information and to the above specified parties. I also understand that I may revoke this authorization, in writing, at any time. This authorization will remain valid until revoked or upon expiration of one year from the date of this signed release.

_____ _____
Client Signature Date

_____ _____
Signature of Parent/Guardian (*if client is minor*) Date

_____ _____
Witness Date

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CLIENT INFORMATION SHEET

NAME OF CLIENT _____

NAME OF PARENT(S)
IF CLIENT IS A MINOR _____

COMPLETE ADDRESS _____
_____
_____

CLIENT DATE OF BIRTH _____

TELEPHONE: (HOME) _____
(WORK) _____
(CELL) _____

EMAIL ADDRESS: _____