GEORGE P. GLASER, LCSW

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CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____ , _____ hereby authorize
(*Client's Name)* *(DOB)*

_____

_____

_____

to release the following types of confidential information about me /my child to **George P. Glaser, LCSW**.

- ❑ Assessment/ Psychological Testing
- ❑ History
- ❑ Progress Notes
- ❑ Treatment Summary
- ❑ Lab
- ❑ X-ray

Such information is necessary for assessment and continuity of care. I understand that I may revoke this consent at any time by informing the above parties in writing. This release is valid until _____.
(*One year duration is recommended*)

I give my permission for Mr. Glaser and other parties to communicate by e-mail:
❑ Yes ❑ No

In consideration of this consent, I hereby release the above parties from any legal liability for the release of this information.

Signature: _____ Date: _____
(*Client)*

Signature: _____ Date: _____
(*Parent or Guardian)*

Signature: _____ Date: _____
(*Witness)*