Susannah Perkins, LCSW
Release of Information

To: _____

_____
Street City State Zip

Telephone Number: _____

Re: _____
Client's Last Name First Middle

Date of Birth: _____ Social Security Number: _____

Legal Address: _____

_____

_____ I hereby give permission to Susannah Perkins, LCSW to release to the above addressee any requested social, educational and/or psychological information that pertains to me.

_____ I hereby request and authorize you to release to Susannah Perkins, LCSW any medical/educational, and/or psychological information they may request which pertains to me.
Send the information to: Susannah Perkins, LCSW
6 Venture, Suite 350
Irvine, CA 92618

This authorization shall be limited to the individual(s) and/or organization(s) named above. Federal law protects the confidentiality of records.

NOTE TO CLIENT: You have the right to receive a copy of this form. You may Revoke this authorization to release information at any time. If you do not revoke it, Your authorization will remain valid.

_____ _____
(Signature of Client) (Parent/guardian if client under 18)

_____ _____
(Date) (Witness) (Date)