GROUPWORKS WEST

3685 MOTOR AVENUE, SUITE 150
LOS ANGELES, CA 90034
310/287-1640

AUTHORIZATION FOR RELEASE OF CLIENT INFORMATION

Client's Name:_____ D.O.B.:___/__ /___
I,_____ or_____
Name of Patient Parent/Guardian

hereby authorize_____
Name of person/Agency

_____
Address (Street,City,State,Zip)

to release/and/or exchange professional and/or medical information regarding my child and/or myself to:

CHRISTOPHER MULLIGAN, LCSW
GROUPWORKS WEST
3685 MOTOR AVENUE, SUITE 150
LOS ANGELES, CA 90034
310/287-1640

Information to be disclosed pertains to the assessment and/or treatment of the following conditions (check pertinent boxes)
___Medical___Drug___Alcohol___Mental Health___School

and should be limited to the following types of information:

___DIAGNOSIS ___DISCHARGE SUMMARY ___PSYCHIATRIC EVALUATION

___PROGRESS NOTES ___PSYCHOLOGICAL TEST RESULTS

___ EDUCATIONAL ASSESSMENT ___BEHAVIORAL REPORTS___ OTHER___

The disclosure is required for:
___EVALUATION___TREATMENT___OTHER_____

This authorization is effective from__ /__/__and maybe revoked at any time by the undersigned. This authorization is good until __/__ /__ I understand I have the right to receive a copy of this authorization.

_____ _____
Signature of Witness Signature of Client Date

_____ _____
Date of Signature Signature Parent/Guardian Date