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AUTHORIZATION TO RELEASE INFORMATION

Client Name(s) _____ / _____

This consent authorizes Laraine Tanzer, LSCW, to release and/or to obtain from and/or exchange information concerning the above names individual (s) regarding:

- _____ Psychological/psychiatric history, assessment, diagnosis, treatment
- _____ Medical history and/or treatment
- _____ Academic and/or educational information, records, testing or history
- _____ Psychological testing results and/or reports
- _____ Psychiatric hospitalization records
- _____ Legal information and/or records

..... with the individual and/or organization listed below:

Name of individual and/or organization: _____

Address: _____

Telephone: _____

FAX: _____

Email: _____

This information is to be used to establish an appropriate treatment plan and/or for continuity of care for the above named individual(s) and/or to help coordinate other treatment and/or services to the individual(s) named above:

Signed : _____ Date: _____

Signed: _____ Date: _____