

Victoria Grinman, LICSW
Growing Kind Minds, LLC
20 Hope Ave. #111
Waltham, MA 02453
Tel: 646.522.0628

AUTHORIZATION FOR THE RELEASE OF INFORMATION

Client's Name _____ Date of Birth ____/____/____

I hereby give permission to Victoria Grinman, LICSW:

_____ to OBTAIN information regarding my care from the below named individuals/agency

_____ to RELEASE information regarding my care to the below named individuals/agency

The individual/agency requesting/releasing information:

Name: _____

Address: _____

Phone: _____ Fax: _____

I have carefully read and understand the above statements and do hereby expressly and voluntarily consent to it. This authorization may pertain to information related to alcohol and drug use/addiction.

I further release Victoria Grinman, LCISW and any other individuals/agency named from any liability arising from the release of information, provided the information is released in accordance with applicable law.

I understand that this directive is subjective to revocation at any time upon request. Otherwise this consent will expire one year from the date signed.

Signature Client/Guardian

Date

Printed Name Client/Guardian

Date