Glenn Wolff, LCSW
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Authorization to Release and/or Obtain Information

For Adults:

Name _____ D.O.B _____

I hereby authorize Glenn Wolff, LCSW to communicate with the following person/agency regarding confidential information that might be useful in treatment planning:

Name/Organization: _____

Relationship to Patient: _____

Address: _____

Telephone Number: _____

I understand that the information to be released and/or obtained is to be used solely for the purpose of treatment planning. This consent is valid until the end of treatment, and it may be voided at any time by my request.

_____ _____
Signature Date