

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

**For Children:**

Child's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

I, \_\_\_\_\_ am the legal guardian of the above named child.

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