



**GROSSMAN &
GROSSMAN LTD**

**Grossman & Grossman, Ltd. Authorization
To Request and/or Release Information**

Regarding Client:

Name:	DOB:
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I authorize Grossman & Grossman, Ltd. to :

- ☐ Request Information _____ (initials of parent/guardian)
☐ Release Information _____ (initials of parent/guardian)

For the following Agency/Provider:

Name	
Address	
Phone	

☐ **Records Authorized:**

- ☐ Intake/Assessment, Treatment and/or Discharge Reports or Summaries
☐ Testing Information prepared by this agency
☐ Other (*specify if checked*):

☐ **Coordination of Care Authorization**

I authorize the staff of Grossman & Grossman, Ltd. (G&G) to have communication with the above provider/agency and its staff and to discuss and share verbal and written information and reports generated in treatment with G&G by phone, email, in-person, and by fax. This information will be used for the purpose of coordination of care. This release is for the agency listed above and covers any changes in agency staff without the need for a new signed release. This authorization will include the participation and sharing of verbal information in staffings/ meetings with other health, mental health or social service providers for treatment purposes.

This authorization will expire one year from the date of the signature below.

I understand that I can revoke this authorization at any time by writing to G&G, but revoking this will not affect disclosures already made or actions taken before the revocation was received by G&G.

Signature of Client date

Signature of Parent or Legal Guardian Authorized to sign if appropriate date

Print Name: _____ Relationship to Client: _____