Fawn Gonzales, LCSW
Independent Practitioner
The Sharing Place
14 Cottage Street
Medford, OR 97504
(541) 779-2390
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Authorization to Use/Disclose Health Information

Client Name: _____ **DOB** _____

I authorize Fawn Gonzales, LCSW, to disclose information to, and obtain information from:

Name: _____

Clinic/Agency: _____

Address: _____

Phone: _____ Fax: _____

Description of information to be disclosed:

____ Unlimited Access
____ Assessments, Consultations & Evaluations
____ Nursing/Doctor/Hospital Medical Information
____ Toxicological Reports/Drug Screens
____ Treatment Plan/Summary
____ Verbal
____ Medication Management Information
____ Demographic Information
____ Chart Notes
____ Diagnosis
____ Educational Information
____ Progress in Treatment
____ Presence/Participation in Treatment
____ Discharge/Transfer Summary
____ Continuing Care Plan
____ Other_____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. I understand that I may revoke this release at any time by submitting a written notification, but that such a request will not apply to any information exchanged prior to the date of such a notification being received by Fawn Gonzales, LCSW. Unless sooner revoked, this consent expires on: _____

Signature of Client: _____ Date: _____

Signature of Parent or Guardian: _____ Date: _____

Signature of Therapist: _____ Date: _____