Theresa Boutross, LCSW
874 GreenBay Rd
Winnetka, IL 60093

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____ _____,
(Name of Client) (Date of Birth)

Authorize the ▫verbal and/or ▫written release and exchange of my confidential medical, psychological, psychiatric, vocational, and/or other information as appropriate

Between the following specific individuals / organizations:

__From __To Theresa Boutross _____

__From __To Spouse/Partner/Family Member:_____

__From __To Health Care Professional:_____

__From __To Lawyer:_____

__From __To Insurance Company:_____

__From __To Employer:_____

__From __To Other:_____

Subject to the following exclusions and limitations:

_____
_____
_____

I understand that I may revoke this consent at any time by informing the above parties in writing.

_____ _____
(Client Signature) (Date)

_____ _____
(Client Signature) (Date)

_____ _____
(Parent or Guardian Signature, If Required) (Date)

_____ _____
(Witness Signature) (Date)

This release of information remains in effect for one year from the date of signature unless otherwise notified