Stella Zweben Samuel, LCSW
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Authorization for Exchange of Information

All information exchanged during the course of our work together will be held in the strictest confidence. I will not release confidential information to anyone without your specific authorization, unless the law requires disclosure. This authorization form specifies with whom information about you may be exchanged, the nature of the information, and the purpose for which it is to be exchanged. This authorization expires thirty (30) days after you cease receiving direct services from Stella Zweben Samuel, LCSW (or on the following date _____). If you have any questions about this form or how it is used, or if you would like a copy of this authorization, please ask me.

I _____, authorize Stella Zweben Samuel,
Client Name (Please print)
LCSW to exchange confidential information with:

_____
Name of Person or Agency (Please print)

_____
Address City/State/Zip

_____
Telephone

Description of information to be exchanged:

_____

_____

_____

Purpose of exchange of information:

_____

_____

_____ _____ _____

Signature of Client Parent/Guardian Date

_____ _____

Stella Zweben Samuel, LCSW Date