Katharine Rossier, MSW, PLLC
Katharine Z. Rossier, LICSW, LCSW, LCSW-C
Psychotherapist

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Authorization for Release of Information

Provider name: ____

Provider address: ____

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Provider phone: ______________________________

I hereby authorize the above named provider and Katharine Z. Rossier, LICSW, LCSW, LCSW-C, to exchange with each other any and all information, both oral and written, concerning my history, condition and treatment, for the purposes of coordinating and improving my treatment. I authorize that this information exchange may continue for one year commencing from the date of my signature below. I understand that I may rescind this authorization at any time through a written statement signed by myself.

In consideration of this request, I hereby release the above parties from any legal liability resulting from the release of this information.

Client signature: _______________________________________ Date: __________________

Client name (printed): _______________________________________

Witness signature: ____________________________________ Date: __________________

Witness name (printed): _____________________________________