Deborah Levi Lane, LCSW, PLLC
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Information to be sent to:

Deborah Levi Lane, LCSW
16019 Via Shavano
San Antonio, TX 78249
Phone: 210-326-4294

Patient Name: _____ DOB: _____ SS# _____

1. I authorize _____ to disclose the following health information about me:

_____ All information/records _____ Progress Notes

_____ Evaluation/Consultation Reports _____ Billing Records

_____ Other _____

2. The information to be disclosed is from _____ to _____ (dates)

3. This information may be disclosed for the purpose of:
   _____ Coordination of Care
   _____ Assistance/Support of Treatment
   _____ Other _____

4. The information may be disclosed until (ending date): _____. If this date is left blank, the authorization will automatically expire in one year from this date.

_____ _____
Patient Signature Date

_____ _____
Guardian Signature (if appropriate) Relationship to Patient