Cognitive Renewal, Inc.,
a Licensed Clinical Social Worker

AUTHORIZATION FOR RELEASE OF INFORMATION

Client: ____ Date of Birth: __________

I, _________________________________ authorize Heather Hansen, LCSW, to disclose/exchange information and records in the course of my own/child's/family's evaluation and treatment to/with:

Name	Telephone
_______________________________________	____________________________________
_______________________________________	____________________________________
_______________________________________	____________________________________

This disclosure or exchange of information is for the purpose of:

________________ Treatment Planning

________________ Educational Planning

________________ Other:____

This information shall be limited to:

________________ History

________________ Progress in Therapy

________________ Other (Specify):____

This authorization shall become void one year from the following date:

____________	__________________________________	____________________
Date	Client/Authorized Representative	Relationship