# Elizabeth C. Graves, M.S.W., L.C.S.W.

## Individual, Couples, Family and Group Therapy

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LCS66244

NPI 1023311370

I hereby authorize:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Name of Agency, Individual, Doctor, School, Hospital, Therapist)

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FAX: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To exchange information from the record of:

*Name of Client: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Date of Birth:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To: **Elizabeth C. Graves, M.S.W., L.C.S.W**

 **744 Pine Street**

 **Paso Robles, CA 93447**

Extent and nature of information to be exchanged: written and/or verbal

* Court Orders
* Entire Record
* Treatment Plan
* Progress Report
* Diagnosis
* Investigations
* Assessments and History

Need and Purpose of Information:

* Coordination of services
* Treatment of client
* Assessment

I understand that I may revoke this authorization to exchange information at any time by giving written notice to Elizabeth C. Graves, LCSW. I also understand that any information released prior to my revocation shall not be a breach of my right to confidentiality. I further understand that I have the right to receive a copy of this authorization.

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

If client is a minor, parent signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_

Effective Dates: \_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_