Gillian Nathan, LCSW
4153 24th Street
San Francisco, CA 94114
(415) 820-1603

Consent for Release of Information:

I, (Parent/Guardian) _____, give Gillian Nathan, LCSW, consent to share information about my child _____ with _____, of _____, at phone number ( )_____, address: _____

_____

This includes written and verbal transfer of history, as well as mental health and treatment information for the purposes of consultation and coordination with relevant professionals. The information shared will be :

□ medical history □ medication □ reason for referral

□ other: _____

_____

for the purpose of:

□ coordinating care

□ other: _____

_____

Unless indicated otherwise, consent will remain valid until rescinded by client.

Signature of Parent/Guardian: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Signature of Client: _____ Date: _____

Signature of Therapist: _____ Date: _____