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

Consent for Release of Information:

I, ____, give Gillian Nathan, LCSW,

consent to share information 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

☐ unrestricted __________________________ ☐ other: _________________________

☐____

____for the purpose of:

☐ coordinating care

☐ other: ____

____

Unless indicated otherwise, consent will remain valid until rescinded by client. This authorization will expire six months from the date treatment is terminated.

Signature of Client:___________________________________ Date: _______________

Signature of Client:___________________________________ Date: _______________

Signature of Therapist: ________________________________ Date: _______________