Christopher Greene, LCSW
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AUTHORIZATION TO RELEASE INFORMATION

Date: _____

I authorize Christopher Greene, LCSW to exchange pertinent information about my treatment, including information relating to the diagnosis or treatment of mental illness, substance abuse or HIV infection with:

Name: _____

Telephone: _____

Street: _____

City: _____

State: _____ Zip Code: _____

This information will be used to facilitate treatment planning and treatment coordination.

This authorization may be revoked at any time and, in any event, will expire on the 30th day following the end of treatment.

_____ _____

Print Name Signature