

**LISA GRAFF-MARSH LCSW  
INDIVIDUAL AND COUPLES THERAPIST**

4985 park Rim Drive  
San Diego, CA 92117  
Office 858-272-9812

**Fax Transmittal**

TO:	
DATE:	
FAX NUMBER:	
PHONE NUMBER:	

**Consent for Release and Exchange of Information**

I authorize Lisa Graff-Marsh, LCSW to exchange any and all information necessary, including but not limited to: records, diagnosis, treatment plan, prognosis, progress to date, and summary of treatment.

[Including psychological,  
physiological, psychiatric, and drug/alcohol related records.  
or other information obtained in the course of diagnosis and treatment of:]

_____ Print Patient's Name	_____ Patient's Date of Birth
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_____ Print Patient's Name	_____ Patient's Date of Birth
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With the following party:

\_\_\_\_\_  
Name

\_\_\_\_\_  
Address

_____ Phone	_____ Fax
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I acknowledge that I have been advised of what information will be disclosed, and understand the benefits and disadvantages of such disclosure. This consent is freely given.

This consent is subject to revocation by the undersigned at any time. If not earlier revoked, it shall terminate without express revocation when disclosure is no longer reasonably necessary.

_____ Signature of Patient	_____ Date
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_____ Signature of Patient	_____ Date
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The information contained in this transmittal is confidential.  
The receiving party is prohibited from disclosing the information to any other unauthorized party.  
If you believe you have received this transmission in error, please destroy all pages and notify the sender immediately.