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**

_____ _____
Print Patient's Name **Patient's Date of Birth**

With the following party:

_____
Name

_____
Address

_____ _____
Phone **Fax**

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**

_____ _____
Signature of Patient **Date**