BETTE GALEN, MSW, LCSW_____
975 Arthur Godfrey Road, #305 , Miami Beach, Florida 33140

AUTHORIZATION FOR RELEASE OF INFORMATION

I , whose date of birth is _____ authorize Bette Galen, LCSW to disclose to and/or obtain from_____

_____
(name/title/organization/address/phone number) the following information:

Please initial each item to be disclosed:

____Assessment ___Diagnosis ____Psychosocial evaluation ____Psychological evaluation ____Treatment plan____Current treatment update ____Intended Parent psychosocial consult ____Recipient psychosocial consult____Donor psychological assessment ____Gestational carrier psychological assessment

Purpose:

The purpose of this disclosure of information is to: 1) improve assessment and treatment planning; 2) share information: 3)relevant to treatment and, when appropriate: 4)coordinate treatment services. Or, the following purpose_____

This authorization is good from /to_____

Signature of Client_____Date_____
Signature of Client_____Date_____

Signature of Bette Galen_____Date_____

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