Deborah Sloss, LCSW
900 N San Antonio Road, Suite 215
Los Altos, CA 94022
650-814-8685
license #LCS27495

TO:

NAME:____

ADDRESS: ____

PHONE: ____

REGARDING:

NAME:____

BIRTHDATE:____

I, ____, hereby give my permission for____to disclose, release, exchange, or mutually discuss information related to the mental health and therapeutic treatment of myself (or my child) named above to Deborah Sloss, LCSW.

This authorization shall become effective immediately and expire in one year from the date of signing. A photocopy or facsimile of this release form is considered to be as valid as the original form. I understand that I have a right to a copy of this release. I understand that I may revoke this release of information at any time by doing so in writing.

Printed name of client (or parent if client is a minor)

____

Signature of client (or parent if client is a minor)

_________________________ __________________________

Relationship to Client __________________________ Date ____________________