

Gillian Nathan, LCSW
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San Francisco, CA 94114
(415) 820-1603

Consent for Release of Information:

I, _____, give Gillian Nathan, LCSW,
consent to share information with _____,
of _____ at phone number: () - _____ address:

This includes written and verbal transfer of history, as well as mental health and
treatment information for the purposes of consultation and coordination with relevant
professionals.

The information shared will be : medical history medication reason for referral
 unrestricted _____ other: _____

_____ for the purpose of:

coordinating care
 other: _____

Unless indicated otherwise, consent will remain valid until rescinded by client. This
authorization will expire six months from the date treatment is terminated.

Signature of Client: _____ Date: _____

Signature of Client: _____ Date: _____

Signature of Therapist: _____ Date: _____