Teri Groves, MSW-LCSW, ACSW, BCD
2240 11th Street, Building D
Mandeville, LA 70471
Phone: (985) 674-4020 Fax: (985) 626-00

Authorization for Release of Information for Minor

Today's Date: _____

Print name of the person for whom the release is authorized:_____

Date of Birth: _____

Address:_____

_____

Print name of legal guardian providing authorization:_____

In signing below, I authorize Teri Groves, MSW-LCSW, ACSW, BCD to, please check all that apply:____ release ____ exchange ____verbal information ____written information ___information limited to (specify)_____regarding psychosocial support/services provided by Teri Groves, LCSW to:

_____
Name of person(s) authorized to receive information

Address:_____

_____

For the Specific Purpose of :_____

_____

_____.

This authorization shall be in effect starting the date signed and expire upon termination of counseling services and/or client's request to withdraw authorization which may occur at anytime deemed by the client.

Guardian's Signature:_____