Steve Szopa, LCSW

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Phone (703) 550-4178
Fax (703) 550-4178

Release/Exchange of Information

I, _____
(Your name)

hereby authorize Stephen M. Szopa, LCSW to release the following information to:

_____.
(Other physician, therapist, professional or company name)

__ My involvement in psychotherapy

__ Medication that I take

__ Social history

__ Psychological assessment

__ Any other information needed to coordinate treatment

I also authorize_____ to release the information checked
(name of other party)

above to Stephen M. Szopa, LCSW. Neither Mr. Szopa nor the person mentioned above will release this information to any other party. This document expires on _____.

(I am aware that I may cancel this release at any time by calling or writing to Mr. Szopa)

Your printed name_____

Your signature_____

DOB _____

Today's Date_____