Elisa E. Nebolsine, LCSW
cognitive therapy for kids

AUTHORIZATION TO RELEASE INFORMATION

Client Name:_____DOB_____

I authorize Elisa Nebolsine, LCSW to exchange information with:

_____
Name of Person, Organization or Institution

_____
Address

_____
Phone Number Email Address

The following information is authorized to be shared:

____Verbal Exchange	____Psychological Evaluation
_____ Email Exchange	____Academic Records
____Neurological Evaluation	____Behavioral Report
____Psychiatric Evaluation	____Medical Records
____Teacher's Report	____Other Information

Effective Date of Authorization:_____

I understand that to revoke this authorization I must put the request in writing and deliver to Elisa Nebolsine, LCSW at 6723 Whittier Ave, Suite 403, McLean, Virginia 22101. This authorization will automatically expire thirty days after the termination of treatment.

_____
Parent/Guardian's Signature Date

_____
Elisa E. Nebolsine, LCSW Date