Sarah Scott Dooling, LCSW
1855 First Avenue
Suite 103
San Diego, CA 92101
www.sarahscottdooling.com

# CONSENT FOR RELEASE OF PROFESSIONAL INFORMATION

Patient's Name:_____ Date of birth: _____

I hereby authorize Sarah Scott Dooling, LCSW to secure and release psychological, medical, social, educational and other clinical information regarding the patient named above. This authorization for an exchange of information applies only to the following individual or institution:

Name/
Institution_____

Contact Number _____

Address_____

Signature: _____ Date_____

Name of Signer (Please print)_____

Relationship to
patient_____