SCOTT LENNOX, LCSW
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Authorization To Contact Others Regarding Your Care

It is accepted mental health practice wisdom that your physician(s), your psychiatrist and others close to you, when appropriate, are involved in your treatment. In order that your rights are respected, please complete the following for this notification and communication.

I authorize Scott Lennox, LCSW to contact and share relevant information with the following persons for the purposes of family history, treatment and discharge planning, and my overall care and wellbeing. I understand that I may withdraw this consent at any time by notifying my Scott Lennox, LCSW in person or in writing.

Primary Care Physican: _____

Address**:** _____
Street City State Zip Code

Contact Number: (_____)_____-_____

FAX Number: (_____)_____-_____

Psychiatrist: _____

Address**:** _____
Street City State Zip Code

Contact Number: (_____)_____-_____

FAX Number: (_____)_____-_____

Legal Counsel: _____

Address**:** _____
Street City State Zip Code

Contact Number: (_____)_____-_____

FAX Number: (_____)_____-_____

Other(s): (please identify) _____

Address**:** _____
Street City State Zip Code

Contact Number: (_____)_____-_____

_____ _____
Client Signature Date

_____ _____
Scott Lennox, LCSW (witness) Date

Note: This is a strictly confidential patient medical record. Re-disclosure or transfer is expressly prohibited by law. A digital or paper copy of this form shall be considered fully valid for authorized uses.