

**SCOTT LENNOX, LCSW**

**PO Box 471036 Fort Worth, Texas 76147  
esslennox@gmail.com  
www.scottlennox.com  
817.223.4279**

**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 release 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 Physician:** \_\_\_\_\_

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