Long Island Cognitive Wellness Counseling Services, LCSW, P.C.
Lianne E. Conroy, LCSW-R
269 West Main Street, Bay Shore, NY 11706
631-913-8201
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www.licognitivewellness.com

LI Cognitive Wellness
CHANGE.ACCEPTANCE.HOPE

_____
DATE

PATIENT INFORMATION

_____
FIRST NAME **LAST NAME** **TELEPHONE NUMBER**

_____
ADDRESS

INFORMATION TO BE EXCHANGED WITH

_____
ORGANIZATION/NAME

_____
ADDRESS

_____
TELEPHONE NUMBER **FAX NUMBER**

TERMS OF AGREEMENT

I, _____, authorize Lianne Conroy, LCSW-R, to receive or send the following information to/from the above person(s)/agency, as authorized below by my initials and signature.

_____ Intake Summary
_____ Treatment Summary
_____ Diagnosis and Treatment Plan
_____ Complete Treatment Record
_____ Other (please specify) _____

I understand that this authorization may be revoked in writing at any time, except to the extent that action has already been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire on the following date, event, condition, or six months from the date of request if no date is specified.

Expiration Date_____

_____
PATIENT SIGNATURE **DATE**

_____
SIGNATURE OF WITNESS **DATE**