Carrie L. Potoff, MSW, LCSW
The Children's and Adult Center for OCD and Anxiety
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Release of Information

I, _____ give permission for Carrie L. Potoff, MSW, LCSW to exchange information about my child. Name of child:

_____

with the following person, persons, or entities:

_____ _____
Name Address/Phone Number

_____ _____
Name Address/Phone Number

_____ _____
Name Address/Phone Number

Carrie L. Potoff, MSW, LCSW will limit its communications to matters necessary for evaluation, treatment and care coordination.

_____
Signature of client or client's parent/guardian

_____
Date