

Patient Name: _____

Date: _____

RELEASE OF INFORMATION

In order to provide quality services, I often need to collaborate with other professionals, such as your primary care doctor, psychiatrist or past therapists. You will be asked to complete a release of information authorizing these exchanges; in some cases I may not be able to provide services without this.

I _____ authorize the release of the following information:
 (please check in the proper box)

Psychosocial Assessment:	Information regarding the scheduling appointments:
Diagnosis:	Treatment Plan Goals:
Acknowledgement that patient is receiving treatment:	Other (please specify):

I hereby authorize Meghan Renzi, LCSW-C, RYT-200 to release the above information to the following person(s) or/ organization:

Name: _____ Phone: _____
 Address: _____

Your consent is valid for one year. Please understand that you have the right to revoke this authorization, in writing, at any time by sending notice. However, a revocation is not valid to the extent that I have acted in reliance on such authorization. If you prefer to decline consent no information will be shared.

 Patient Name Signature Date

 Guardian Name Signature Date

 Guardian Name Signature Date

 Witness Name Signature Date

¹ Revised March 2016