4405 East West Highway, Suite 502
Bethesda, MD 20814
(240)479-4894

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 a 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