Greene Psychology Group

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CONSENT TO RELEASE AND EXCHANGE PATIENT INFORMATION

At my request, I, (client)_____, hereby authorize Greene Psychology Group and (independent therapist) _____ to obtain and/or release information regarding:

Client Name: _____DOB:_____

This information should only be exchanged via telephone or written information with:

Name/Agency: _____

Address:_____

Phone Number: _____

Specific information to be released: _____

For the specific purpose of: _____

I understand that this form is not required as a condition for treatment. I understand that I have the right to revoke this authorization, except to the extent that action has already been taken, in writing, at any time by sending written notification to Greene Psychology Group and therapist. A copy of this authorization is considered as authentic as the original signed consent, as the original will be retained in my records. This consent is valid for one year from the date of signature, unless an alternative date is noted here: _____.

Signature:_____Date:_____

Printed Name:_____

Relation to Client (if applicable): _____