

Kentlands Psychotherapy

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RELEASE OF INFORMATION

I, _____, hereby authorize Dr. Elizabeth Carr of Kentlands Psychotherapy to release information pertaining to my evaluation and/or psychotherapy sessions to:

for the purpose of: _____
(indicate the specific reason)

I understand that authorization shall remain valid from the date of my signature below and for 12 months thereafter ending on: _____

I have been informed that I may revoke this authorization by written or oral communication to the Dr. Carr at any time. I certify that this form has been fully explained to me and that I understand its contents.

Signature of Patient/Client

Date of Authorization

Printed Name of Patient/Client