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Request For and Consent to Release Information of Mental Health Treatment

Client's Name: _____

Address: _____

_____

Date of Birth: _____ Telephone No. _____

Name and address of Person/Program/Agency to whom information is to be released and/or requested:

_____

I request and authorize Jill Rubin, LICSW to release and receive information pertinent to my mental health treatment to/from the person, organization, agency named on this request. Specific information requested:

_____

_____

Concerning the period(s) from _____ to _____

The purpose of this disclosure is to:

_____

I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. If not otherwise noted, this consent will expire automatically when termination of treatment occurs.

_____ _____

Date Client or Guardian or Executor Signature