Michele Saffier, LMFT, CSAT-S
Clinical Director & Co-Founder
Director & Co-Founder

CENTER FOR HEALING
-Self and Relationships-

Arlene Rosen, LMFT, CSAT
Clinical

Release of Information Consent

I hereby authorize: _____

To share with and/or forward/receive information to:

_____ (therapist) at The Center for Healing Self and Relationships. It is understood that this consent to release/receive information will expire upon written notice.

Date of Treatment: _____

Specific information requested includes:

_____

_____

Purpose for this disclosure:

_____

_____

Patient name: _____

Date of Birth: _____

Patient Signature: _____

Date: _____

Parent/guardian signature if minor client: _____