Dahlia Greenbaum, M.A., LMFT

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Release of Information

I, _____, hereby authorize and request that the parties named below release and share all confidential medical, psychological, educational and/or other appropriate information needed for my assessment and treatment, or that of my minor children, _____ with Dahlia Greenbaum, LMFT. I also authorize Dahlia Greenbaum to release any appropriate information to the parties named, unless specific limitations are noted.

(1) Name and Relationship:_____
Address and Phone: _____
Purpose: _____

(2) Name and Relationship:_____
Address and Phone: _____
Purpose: _____

(3) Name and Relationship:_____
Address and Phone: _____
Purpose: _____

This consent will expire one year from today, unless another date is specified: _____. I understand that I may revoke this consent at any time by informing the parties above, and Dahlia Greenbaum in writing. I hereby release the above parties from any legal liability due to the release of information.

Signed: _____ Date: _____

Print Name: _____

Signed: _____ Date: _____

Print Name: _____