



Garden City
 Marriage & Family Therapy
 520 Franklin Avenue, Suite 213
 Garden City, NY 11530

Authorization for Release of Information

I authorize *Garden City MFT* and/or _____ to release
 (therapist)

information to:

 (Receiving person and institution/agency/organization) (Address)

For the purpose of

This consent is valid until _____

I understand that I may revoke this consent at any time and that the above-named person authorized to receive this information has the right to inspect and copy the information to be disclosed.

It has been explained to me that if I refuse to consent to the release of information, the following are the consequences (specify, if any):

 (Signature)

 (Witness)

 (Date)

 (Date)