CENTER FOR ASSESSMENT AND PSYCHOTHERAPY

Authorization Consenting Release Of Information

I authorize Dr. Mary Murphy to **discuss** verbally and or in writing anything that has been brought up during our psychotherapy or evaluation **with** any person/s or staff of clinic, office, agency, or institution/s named below and **receive** any relevant information **from** them.

1. _____
2. _____
3. _____
4. _____

For the following reason(s):

____ Consultation/Psychotherapy,

____ Evaluation,

____ Coordination of care

____ Other: _____

I may revoke this consent at any time. This consent is in effect for five years from the date of the last session, unless revoked in writing earlier or renewed. This consent is also subject to all conditions outlined in the Office Policies (Form #1).

_____	_____	_____
Patient Name (print)	Signature	Date
_____	_____	_____
Parent / Guardian Name (print) (If applicable)	Signature	Date