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Consent to Release Information

I, _____, authorize _____ to
____ (send) ____ (receive) information regarding _____
____ (to) ____ (from) the following agency or people:

Name: _____

Agency/Organization: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

The above information will be used for the purpose of:

I understand that I may revoke this consent at any time, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

Client's signature: _____ Date: _____

Parent signature (if under 18) _____ Date: _____

Therapist's signature: _____ Date: _____