Michael Brendler, Psy.D.

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Consent to Release Treatment Information

I hereby authorize Dr. Michael Brendler to exchange information related to assessment and/or treatment of the patient listed below with:

name: ______________________________ phone:______________________
name: ______________________________ phone:______________________
name: ______________________________ phone:______________________
name: ______________________________ phone:______________________

I understand that I have the right to receive a copy of this authorization. The disclosure of records and information authorized herein is requested for the purposes of assessment and treatment of the patient listed below.

The specific types of information and the uses of the information to be disclosed shall be limited in the following ways:

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This authorization shall be valid until________________, or for one year, whichever comes first, and may be revoked in writing at any time. A fax or copy of this document shall be considered valid.

____
Patient's name (print)

____________________________________ ______________________
Patient's signature Date