THE CENTER FOR COGNITIVE THERAPY

CONSENT FOR RELEASE OR EXCHANGE OF CONFIDENTIAL INFORMATION

I_____ (Note: Parent/Guardian's name if client is under 18) hereby authorize the release and exchange of information between my therapist, _____ and the following individual, agency or institution(s):

_____

This authority extends to the furnishing of copies of all or any desired portion of the records pertaining to the above-named client. This exchange is for the purpose of

_____

and expires two years from the date signed unless otherwise specified.

The client has the right to retain a copy of this release. The parties named above are hereby released from all legal liability that may arise from this exchange or release of information. I understand that I may revoke this exchange or release of information at any time by informing the above parties in writing.

_____

Name of Client

_____ _____

Client/Guardian Signature Date

_____

Relationship to Client (If client is under 18)