KAREN ROSE, MFT
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AUTHORIZATION CONSENTING TO RELEASE OF INFORMATION

I authorize _____ to release

_____to any person/s or staff of clinic,

office, agency, or institution/s named below and receive any relevant information from them.

1. Name: Phone:
2. Name: Phone:
3. Name: Phone:

For the following reason(s):
_____Consultation/Psychotherapy,
_____Evaluation,
_____Other: _____

I may revoke this consent at any time. This consent is in effect only 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.

_____ _____ _____
Name (print) Date Signature