

# Center For Cognitive Therapy

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## AUTHORIZATION FOR RELEASE OF INFORMATION

I \_\_\_\_\_ hereby authorize \_\_\_\_\_  
(client's full name) (address) \_\_\_\_\_

(address) \_\_\_\_\_

Phone ( ) \_\_\_\_\_ Fax ( ) \_\_\_\_\_

to release to the Center for Cognitive Therapy copies of legal, medical, psychiatric, psychological, and educational information which may have been acquired in a professional capacity concerning my evaluation and/or treatment of: (specify date or dates)

The information being released is: \_\_\_\_\_  
(specify nature/extent of released information)

for the purpose of: \_\_\_\_\_  
(specify reason for information to be released)

*I understand that I may revoke this consent to release information by oral or written communication. I also understand that any release which has been made prior to my revocation and which was based upon this authorization shall not constitute a breach of my right to confidentiality.*

Unless I revoke this authorization prior to such time, it shall remain valid for 180 days ending on \_\_\_\_\_

\_\_\_\_\_  
(signature of client)

\_\_\_\_\_  
(DOB)

\_\_\_\_\_  
(authorization date)

\_\_\_\_\_  
(parent, guardian, or legal representative)

\_\_\_\_\_  
(authorization date)

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
(signature of staff witnessing consent)

\_\_\_\_\_  
(date)