Deborah Weisberg, LMFT, LPCC
Psychotherapy

CONSENT FOR RELEASE OF INFORMATION

PATIENT NAME _____

DATE OF BIRTH _____

This release of information form authorizes information from my records regarding diagnosis, symptoms and treatment to be shared between Deborah Weisberg, LMFT, LPCC and the person or agency listed at the bottom of this form.

I understand that this authorization is valid for two years from the date listed below. I also understand that this information may not be released to any other person or organization without my permission in writing. A photocopy of this authorization shall be considered valid.

_____
Name, Agency, School, or Individual

_____
Address

_____
City Zip

_____ _____
Signature of Parent/Guardian/Client Date

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Licensed Marriage & Family Therapist, MFC 50800
Licensed Professional Clinical Counselor, LPCC 730