Authorization Consenting To Release of Information

I authorize Bridget Tremblay PsyD, LMFT to **discuss** (verbally or in writing) anything that has been brought up during our psychotherapy or evaluation **with** any person/s or staff of clinic, office, agency, or institution/s named below and **receive** any relevant information **from** them.

1. _____
2. _____
3. _____
4. _____

For the following reason(s):

____ Consultation/Psychotherapy,

____ Evaluation,

____ Other: _____

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

_____ _____ _____

Name (print) Date Signature

_____ _____ _____

Name (print) Date Signature

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