

## Authorization Consenting To Release Of Information

I, \_\_\_\_\_, authorize Magee Madry Counseling Services, LLC to discuss and exchange, in verbal or written form, any relevant information to my treatment with the person, or any person(s) or staff of the institution, named below.

---

Name/Institution Name

---

Address

---

Phone Number/Fax Number

For the following reason(s):

\_\_\_\_\_ Psychological Assessment

\_\_\_\_\_ Medical Records

\_\_\_\_\_ Coordination of Care

\_\_\_\_\_ Other: \_\_\_\_\_

***You may revoke this consent at any time. Unless otherwise revoked or renewed, this consent is in effect for one year from the date of the last session. This consent is subject to all conditions outlined in the Offices Policies & Consent to Treatment.***

---

Client/Legal Guardian Signature

---

Date