

RELEASE OF INFORMATION

Jennifer S. Battaglino, LCSW

178 Myrtle Blvd., Suite 107, Larchmont, NY 10538

(914) 315-4044

I, _____, give my permission for Jennifer Battaglino, to discuss my case with the following therapist (name, address, and phone number follows)

If you would like information discussed with a third party other than a therapist, please provide details of the relationship and the reason for release.

I, _____, give my permission for Jennifer Battaglino to discuss my case with the following:(Name, address, phone, relationship follows)

Please provide reason for discussing information as well as any limits to the information discussed.

ENDING THIS AUTHORIZATION

Select one of the following two choices.

_____ This authorization will end on the following date _____

_____ This authorization will end when the following happens. The event must relate to the individual or the purpose of the authorized use and/or disclosure. Describe the event below:

I release any information or records which Jennifer Battaglino and the aforementioned party/ parties deem necessary to exchange regarding my treatment.

Client signature and Date

Print Name