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Family Counseling and Mediation Services, Inc.

12 Amity St.
Spencerport, NY 14559
585-594-2687

CONSENT FOR RELEASE OF INFORMATION

I hereby give permission to

THERAPIST: _____
Of : Family Counseling and Mediation Services, Inc.
12 Amity Street
Spencerport, NY 14559
(585) 594-2687

to release and/or receive information from my medical /clinical record. (i.e. Medical, Social, Educational, Psychiatric, Psychological)

To/From: **NAME:** _____
AGENCY: _____
STREET: _____
CITY: _____ **STATE:** _____ **ZIP:** _____
PHONE: _____

I understand that the information to be released is confidential and protected from disclosure. I also understand that I have the right to cancel my permission to release information at any time before it is released.

CLIENTS NAME: _____ DOB: _____
ADDRESS: _____

SIGNATURE: _____ **DATE:** _____

RELATIONSHIP (if other than self) _____

WITNESS: _____ **DATE:** _____