

Mark Ettensohn, Psy.D.

Licensed Clinical Psychologist | PSY 25461

AUTHORIZATION CONSENTING TO RELEASE OF INFORMATION

I, _____, authorize Mark Ettensohn, Psy.D. 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 Treatment Agreement and /or Psychological Testing Consent form.

Date: _____

Signature: _____