THE CENTER FOR TREATMENT OF ANXIETY AND MOOD DISORDERS

Statement of Release

Authorization to Request and/or Release Information

Client's Full Name: _____ Date of Birth: _____/_____/_____

I authorize Center for Treatment of Anxiety and Mood Disorders to request and exchange confidential professional information, including personal, psychological, medical records and opinions, with:

_____

Name of Person or Organization

_____ _____

Street Address Phone

_____ _____ _____

City State Zip Code

_____

Name of Person or Organization

_____ _____

Street Address Phone

_____ _____ _____

City State Zip Code

_____

Name of Person or Organization

_____ _____

Street Address Phone

_____ _____ _____

City State Zip Code

I understand that I have no obligation whatsoever to disclose the requested information and that I may revoke this consent at any time by informing the Center for Anxiety and Mood Disorders or the above named parties. In consideration of this consent, I hereby release the Center for Anxiety and Mood Disorders and the above named parties from any and all liability arising therefrom.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Print Name Relationship to Patient