Connections Wellbeing Center Information Release

Client____

Date of Birth_____________________________

I hereby authorize the release of information and/or psychological reports regarding the above-named person **TO / FROM**:

Aviva Kohl, LCSW-R 845.269.5008
16 Wits End
Spring Valley, NY 10977

TO / FROM:

Name:_______________________________________

Address:____

Relationship to Client:____

Contact information: (phone, fax, email)____

____

Limitation of information: (Please initial)____ I hereby limit the information shared to the following only:____

____

Signature:____ Date:______________________

Printed name(signed by):_____________________________ Relationship: __Parent __Guardian

Address:____