Sonia Bhatia, Psy.D., LMFT, Resolve Counseling LLC
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CONFIDENTIAL RELEASE OF INFORMATION

I _____ hereby authorize Sonia Bhatia, Psy.D. LMFT to release to:

Name _____

Address _____

_____

City State Zip Code _____

Phone number and/or Fax number, including area code (_____)_____

Information regarding services received for the purpose of:

_____

Client Name: _____
(please print)

This consent is valid until _____ (six months maximum before a new release form is signed) (please specify date)

I understand that I may only revoke my consent to share information with the person/organization in this form by notifying Sonia Bhatia, Psy.D. LMFT in writing. I further understand that, after this date, I will need to sign a new release form should I wish to continue to authorize the release of information.

Client Signature: _____ Date: _____

Current Address: _____

_____

Phone Number: _____

Email Address: _____