RELEASE/OBTAIN INFORMATION CONSENT FORM

RITA PRELLER LCSW-C PSYCHOTHERAPY, INC.
1615 YORK ROAD, SUITE 209
LUTHERVILLE, MD 21093
PHONE: 410-323-1984
FAX: 443-519-5137

Patient's Name: _____

Patient's Date of Birth: _____

I, _____ authorize Rita Preller LCSW-C Psychotherapy, Inc. to (release) (obtain) records (to) (from):

1._____

2._____

3. _____

This information will be used for the purpose of coordinating and the recommendation psychotherapeutic treatment.

This release will expire in one year; I understand that I may revoke this release at any time.

Signed: _____

Relationship to patient: _____

Date: _____