MAIN LINE THERAPY
CENTER

Jennifer Torresson, LMFT
PA License# MF000903

Consent to Release Information

I, _____(Name of Client), Date of Birth:___/___/___, request and give permission to Main Line Therapy Center, Jennifer Torresson, LMFT, Owner, to:

Disclose Information To:	YES	NO
Communicate With:	YES	NO
Obtain Information From:	YES	NO

Agency: _____
Address: _____
Phone: _____
Fax: _____

Regarding the following information (Check items to be released / received):

Attendance	____	Educational Records	____
Health Records	____	Psychiatric Evaluation	____
Psychological Testing	____	Psycho-Social Summary	____
Progress Notes	____	Termination Summary	____
Treatment Plan	____	Other:_____	____

The purpose of this release of information is for: _____

This release is valid from ___/___/___ to ___/___/___.

AGREEMENT AND CONSENT

Your signature below indicates that you have read this Consent to Release Information. By signing below, you indicate your understanding and agreement to the above. You understand that you may revoke this Consent to Release Information at any time and must do so in writing.

Client Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Parent / Guardian Signature: _____ Date: _____