RELEASE OF INFORMATION

Patient Name: _____ DOB _____

Address: _____

I _____AUTHORIZE

BLACK THERAPIST & COMPANY, LLC

TO RELEASE THE FOLLOWING INFORMATION TO:

NAME:

ADDRESS:

EMAIL:

PHONE:

INFORMATION TO BE RELEASED (BE SPECIFIC):

_____

_____

_____

_____

Patient Signature: _____

PRINT NAME: _____

DATE: _____

OTHER SIGNATURE: _____

PRINT NAME: _____

DATE: _____

RELATIONSHIP TO PATIENT: _____


B&C
Black Therapist & Company