VERITAS PSYCHOTHERAPY
Individual, Couple & Family Counseling

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RELEASE OF INFORMATION

_____ ____ M ____F _____/___/____
Printed Name of Patient or Client *Sex* *Date of Birth*

Maureen Newberg, L.C.S.W. has my permission to:

____ Verbally transmit ____ Send ____ Receive - the information checked below to/from:

_____
_____
_____
_____

Use a separate form for each person or agency with which information may be shared.

Initial all items covered by this release.

____ Collaborate in planning, providing, or coordinating services.
____ Acknowledgment of receipt of services.
____ Treatment Plan
____ Psychiatric Evaluation
____ Intake Assessment
____ Progress Notes
____ Diagnosis
____ Psychological Evaluation
____ Complete Record
____ Other (specify)_____
____ Other (specify)_____

This information is being shared for the purpose of:_____
_____

This authorization is valid (check only one): ____ Until Withdrawn

I understand that I can withdraw this consent at any time.

_____ _____
Signature of Patient or Client Date

_____ _____
Signature of Patient or Client Date

_____ _____
Signature of Parent, Guardian, or other Authorized Person Date

_____ _____
Therapist Date