HELEN MARLO, PH.D.
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RELEASE OF CONFIDENTIAL INFORMATION:

- Please write in **your phone number**: _____
- I,_____,authorize Helen Marlo, Ph.D.:

____ (please initial) **to RELEASE verbally or in writing any material** from any professional services she has rendered to me (including, but not limited to, psychotherapy, consultation, psychodiagnostic testing) to the person(s) or staff of the clinic, office, agency or institution named below.

____ (please initial) **to RECEIVE any information** from the person(s) or staff of the clinic, office, agency or institution named below.

_____ (please initial) **to RELEASE verbally or in writing ONLY the following material** from any professional services she has rendered to me:

_____

_____

This applies to services rendered (specify dates, if applicable): _____

____ (please initial) **to RECEIVE verbally or in writing ONLY the following material** from professional services rendered to me:

_____

_____

This applies to services rendered (specify dates, if applicable): _____

1. Name & Institution: _____
   Address, City, Zip: _____
   Phone: Area Code (_____) _____
2. Name & Institution: _____
   Address, City, Zip: _____
   Phone: Area Code (_____) _____
3. Name & Institution: _____
   Address, City, Zip: _____
   Phone: Area Code (_____) _____

For the following reason(s): _____

_____

This consent may be revoked by me at any time and is in effect only for three years from the last session unless otherwise revoked or renewed.

Signatures:

Patient: _____ Date: _____

Patient: _____ Date: _____

Witness: _____ Date: _____